

# EMS SERVICE ZONE PLAN APPLICATION

## BOSTON, MASSACHUSETTS



*REGIONAL OFFICIAL USE ONLY*

Plan Date Received	Plan Reviewed	Plan Returned with Recommendations	Recommended To OEMS
7/5/06	7/7/06-10/2/06	10/2/06	3/2/07

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Plan Date Received	Reviewed By	Plan Approved	Plan Returned with Recommendations	Plan Updated
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# Boston, Massachusetts

## EMS Service Zone Application

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PART A: Service Zone Identification

	<b>MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH</b> <b>OFFICE OF EMERGENCY MEDICAL SERVICES</b> <b>SERVICE ZONE PLAN APPLICATION TEMPLATE</b>
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**Boston Emergency Medical Services**

*Agency Name*

12-26-06

*Date*

Identify the local jurisdiction(s) in the service zone: **Boston, Massachusetts**

I, the undersigned, attest that I am duly authorized to complete and sign this application, that I have read this application in its entirety and that the information contained herein is complete, accurate and true, Signed under the pains and penalties of perjury.

**Authorized Signature**

[submitted with application]

**Chief of Department**

**Agency Location**

**767 Albany Street**

*Street Address: Number, Name, Type, Unit #*

**Boston**

*City/Town*

**MA**

*State*

**02118 -**

*Zip*

**617 - 343 - 2367**

*Phone: Area Code, Number, Extension*

**617 343 - 1199**

*Fax: Area Code, Number, Extension*

**ServiceZone@BostonEMS.org**

*Primary Email Address*

**Name of Agency Contact**

**Brendan**

*Name: First*

**Kearney**

*MI*

*Last*

**Superintendent**

*Title*

**767 Albany Street**

*Street Address: Number, Name, Type, Unit #*

**Boston**

*City/Town*

**MA**

*State*

**02118**

*Zip*

**617 - 343 - 2367**

*Phone: Area Code, Number, Extension*

**617 - 343 - 1199**

*Fax: Area Code, Number, Extension*

**Kearney@BostonEMS.org**

*Primary Email Address*

**Signature Page**

**Name of Person Completing Application**

<u>Brendan</u>	<u>M</u>	<u>Kearney</u>	<u>Superintendent</u>
<small>Name: First</small>	<small>MI</small>	<small>Last</small>	<small>Title</small>
<u>617 - 343 - 2367</u>		<u>617 - 343 - 1199</u>	
<small>Phone: Area Code, Number, Extension</small>		<small>Fax: Area Code, Number, Extension</small>	

**Person responsible for monitoring compliance of local jurisdiction(s) with the service zone plan:**

<u>Brendan</u>	<u>M</u>	<u>Kearney</u>	<u>Superintendent</u>
<small>Name: First</small>	<small>MI</small>	<small>Last</small>	<small>Title</small>
<u>617 - 343 - 2367</u>		<u>617 - 343 - 1199</u>	
<small>Phone: Area Code, Number, Extension</small>		<small>Fax: Area Code, Number, Extension</small>	

ServiceZone@BostonEMS.org  
Primary Email Address

**Authorized MBEMSC**

**Signature:** \_\_\_\_\_ [submitted on application]

**Date:** \_\_\_\_\_

<u>John</u>	<u>P.</u>	<u>Guidara</u>	<u>Executive Director</u>
<small>Print Name: First</small>	<small>MI</small>	<small>Last</small>	<small>Title</small>

<b>EMS Region</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
	Western MA	Central MA	Northeast	<a href="#">Metro Boston</a>	Southeast

**The chief municipal official of the local jurisdiction covered by the service zone plan must sign this application. If the service zone is comprised of multiple local jurisdictions, the chief municipal official of each local jurisdiction must sign this application.**

I, the undersigned, attest that I am duly authorized to complete and sign this application, that I have read this application in its entirety and that the information contained herein is complete, accurate and true, Signed under the pains and penalties of perjury.

**Authorized Signature** \_\_\_\_\_ [submitted on application]

City of Boston

Local Jurisdiction

<u>Thomas</u>	<u>M</u>	<u>Menino</u>	<u>Mayor</u>
<small>Print Name: First</small>	<small>MI</small>	<small>Last</small>	<small>Title</small>



## City of Boston, Massachusetts

### City of Boston Overview

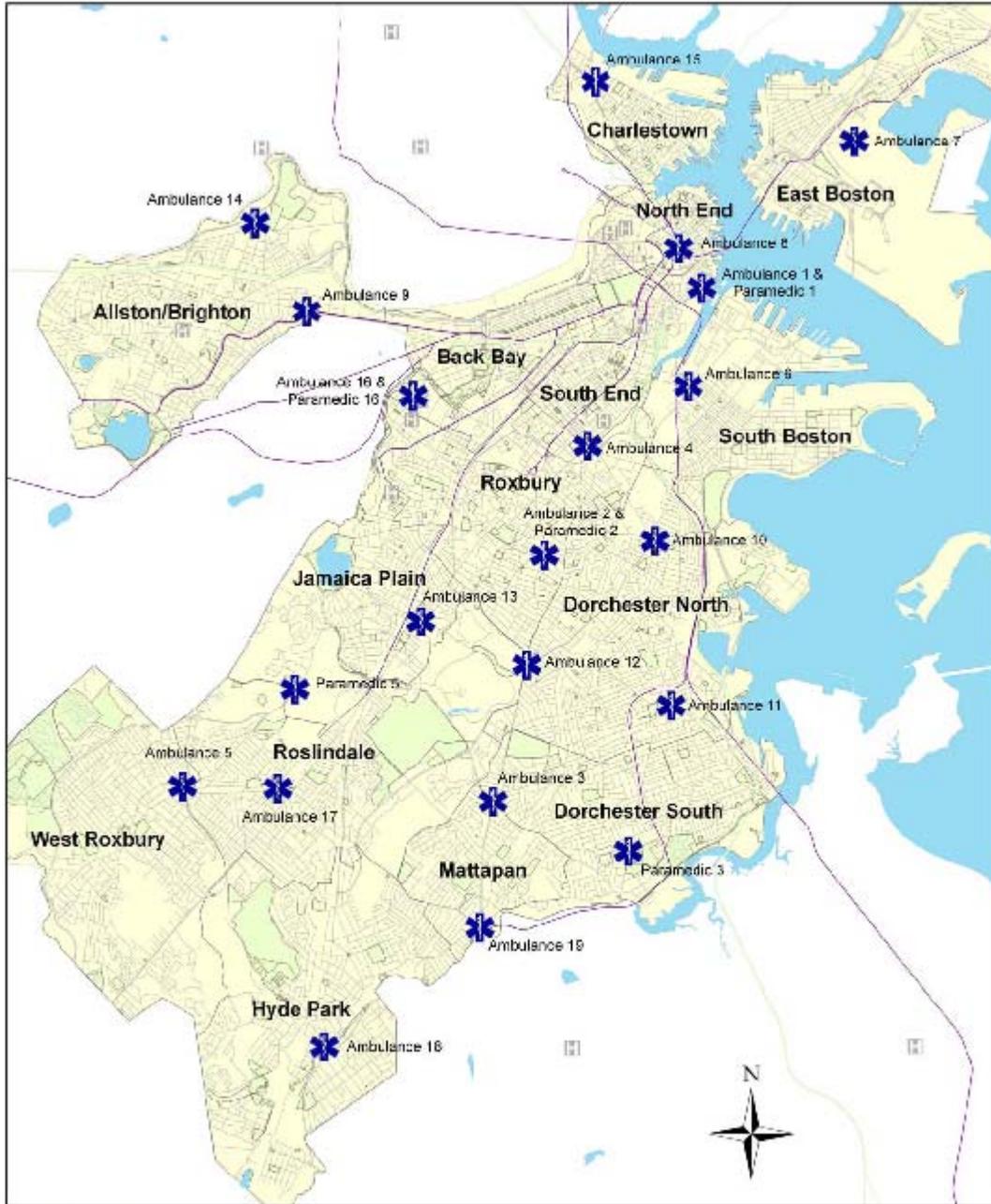
The City of Boston is the capital city of Massachusetts and is the Commonwealth's largest city, with a resident population of over 608,000 and a daytime population that swells to well over one million. Boston is the center of a metropolitan area of more than 4.2 million people, while the total population of Massachusetts is approximately 6.3 million residents. Boston encompasses 45.7 square miles and is governed by a mayor/city council form of government.

Often described as a “city of neighborhoods” Boston is comprised of 19 diverse communities:

1. Allston/Brighton	11. Jamaica Plain
2. Back Bay	12. Mattapan
3. Beacon Hill/West End	13. Mission Hill
4. Charlestown	14. North End
5. Chinatown/Leather District	15. Roslindale
6. Dorchester	16. Roxbury
7. Downtown	17. South Boston
8. East Boston	18. South End/Bay Village
9. Fenway / Kenmore	19. West Roxbury
10. Hyde Park	

The City of Boston is home to more than 20 short and long-term care hospitals and dozens of public and private colleges and universities. Major transportation networks, including Logan International Airport, a \$6 billion per year critical infrastructure are located in the City. Boston is also home to several major transportation hubs, including North Station and South Station. The Port of Boston is the largest container port in New England and is the 22<sup>nd</sup> largest in the United States. Liquefied Natural Gas (LNG) deliveries travel through the Port of Boston to Chelsea Creek on a weekly basis. Given Boston's historic significance, its position as a world-renowned research and academic center, its designation as the capital city of Massachusetts and the largest city in New England, the Federal government has designated Boston as an Urban Area Security Initiative (UASI) Region. The Metropolitan Boston Homeland Security Region (MBHSR) includes the cities of Boston, Cambridge, Chelsea, Everett, Quincy, Revere, and Somerville, as well as the towns of Brookline and Winthrop.

# Service Zone Area Map



City of Boston  
Boston EMS Ambulances





## BOSTON EMS

### **Boston EMS: Department Overview**

Boston Emergency Medical Services is the lead agency for the provision of emergency medical services within the City of Boston. A bureau of the Boston Public Health Commission (BPHC), Boston EMS is one of the country's oldest providers of pre-hospital care, with a history that dates back over 100 years when the Department was known as the City Hospital Ambulance Service. In 1996, the Boston City Hospital privatized and merged with Boston University Hospital and a new organization, the Boston Public Health Commission (BPHC), was established to carry on the public health activities of the City. Since that time, BEMS has been a bureau of BPHC. Today the Department is widely recognized as one of the premier emergency service organizations in the country. Additionally, Boston EMS is a recognized leader in the field of emergency preparedness and takes an active role in preventing and mitigating emergencies across the City.

As part of the Boston Public Health Commission, Boston EMS has been able to maintain its public focus and mission. As a result of its connection with the Commission, Boston EMS has strengthened its education and prevention outreach efforts, with the goal of minimizing the effects of crisis situations. Boston EMS is not only responsible for providing emergency care, but for serving the Commission's public health goals. The Department's motto is "Where public health meets public safety".

#### *Mission*

Boston Emergency Medical Services is a community based public health and public safety service that provides and manages the integrated pre-hospital care system for the City of Boston to improve the health of the community

#### *Vision*

- Boston Emergency Medical Services treats everyone with respect, compassion, and professionalism, always putting the needs of the patients and community first.
- Boston Emergency Medical Services provides the best pre-hospital care in the county, provides national leadership in uniting public health with public safety, and is recognized as the leading EMS agency in the United States.
- Boston Emergency Medical Services uses research and training to innovate and adapt, ensuring that BEMS is always at the cutting edge of meeting the changing and emerging needs of the community.
- Boston Emergency Medical Services recognizes its commitment to staff diversity and excellence through comprehensive development and training programs and opportunities.

*Values*

- Commitment and Dedication
- Pride and Accountability
- Honesty and Trust
- Respect and Dignity
- Compassion and Caring
- Communication and Collaboration

**Definitions**

The following terms and abbreviations are commonly used in Boston EMS and throughout this service zone application:

Administration:	The management and command level of Boston EMS including administrative staff assigned to EMS Headquarters;
ALS:	Advanced Life Support: a paramedic unit or the advanced procedures and skills performed by an EMT-Paramedic;
Associate Medical Director:	A physician employee of the Department who assists the Medical Director with ongoing Department training, quality assurance, and research projects. May function as medical director or department liaison on special projects;
BLS:	Basic Life Support: a Basic Life Support ambulance or the procedures and skills performed by an EMT-Basic;
Cadet or EMS Intern:	An employee in training to become eligible as a Recruit EMT;
Captain:	A ranking officer with supervisory and inspectional responsibilities as assigned; subordinate to a Command Staff Officer and superior in rank to a Lieutenant; the “Training Supervisor” and “Principal EMT” job titles hold the rank of Captain;
Chief of Department:	Highest ranking Command Staff member charged with authority and responsibility for overseeing the day-to-day operations of the Department;

CMED:	Central Medical Emergency Direction; Boston EMS is the contracted provider of CMED Services for Massachusetts EMS Region IV;
CMR:	Code of Massachusetts Regulations;
COB	City of Boston;
COBTH:	The Conference of Boston Teaching Hospitals; a consortium of area receiving hospitals participating in providing medical care and disaster management to the Boston area;
Command Staff:	The command level of Boston EMS with responsibility for coordinating and directing all activities of the Department;
Deputy Superintendent	A member of the Command Staff with authority and responsibility for a particular shift, special event, or special project; superior in rank to Captain, and subordinate to Superintendent;
District:	A geographical area of the City comprised of census tracts, for the purpose of establishing ALS and BLS response and service areas;
Division:	A geographical portion of the City comprised of one or more districts (e.g. Division 1, Division 2); a component of a Bureau of Boston EMS;
DPH:	The Massachusetts Department of Public Health;
Emergency Medical Technician (EMT):	A generic term describing all levels of certification as set forth in the Massachusetts General Laws, Chapter 111c and the pertinent regulations under the law;
BEMS EMT-Basic:	A Department employee, certified by the Massachusetts Office of Emergency Medical Services, who has successfully completed the Boston EMS recruit training and field internship, and has become certified by the Department to perform Basic Life Support Skills in accordance with Statewide and Boston EMS protocols and special project waivers;

BEMS EMT-Paramedic:	A Department EMT, certified by the Massachusetts Office of Emergency Medical Services as an EMT-Paramedic, and who has successfully passed the Boston EMS Paramedic selection process, and subsequently successfully completed the Boston EMS Advanced Life Support (ALS) clinical training and field internship and is certified by both State regulations and Boston EMS policies to perform ALS skills in accordance with Statewide and Boston EMS protocols and special project waivers;
BEMS EMT-Recruit:	An employee who is undergoing a didactic orientation or a field internship in order to be considered for promotion to EMS EMT-Basic;
ETA:	Estimated Time of Arrival;
Executive Director:	The Executive Director of the Public Health Commission;
First Responder:	Public safety personnel trained in CPR and basic first aid, as set forth by 105 CMR 171.000, the Massachusetts First Responder Training Regulations;
Lieutenant:	A supervisory officer with administrative and clinical responsibility and authority over EMTs, recruits, and EMS interns, and administrative responsibility and authority over EMT-Paramedics. Lieutenants may be assigned operational supervision over Field Units and Dispatch Operations personnel. Formerly referred to as Senior EMT;
MCI:	Multiple (or Mass) Casualty Incident;
Medical Director:	The designated emergency physician with overall responsibility for clinical protocols, clinical standards and practices, clinical training, research projects, medical control, physician support to Boston's public safety agencies (police, fire, EMS) and physician overview of medical continuous quality improvement activities;

Patient Care Report (PCR):	The designated form or electronic template for documenting all aspects of patient assessment and treatment. It is completed for each ambulance response or other incident unless the unit is canceled prior to arrival. Also referred to as a trip sheet;
PHC:	The Boston Public Health Commission. Boston EMS is a bureau of the PHC;
Section:	A component of a Division of Boston EMS; also a functional subdivision within the Incident Command System;
Service Zone Plan:	In accordance with MGL c 111C, a comprehensive plan that defines the local EMS resources and describes how those resources will be used and coordinated;
Shift Commander:	A Department certified EMT-Paramedic member of the Command Staff with authority and responsibility for a particular shift, division, or special project; holds the rank of Deputy Superintendent;
Stations:	Designated base locations or quarters for Department personnel and equipment;
Superintendent:	A ranking Command Staff Officer superior to Deputy Superintendent, and subordinate to the Superintendent in Chief;
Superintendent in Chief:	A ranking Command Staff Officer with responsibility for all uniformed members of the service; superior to Superintendent and reports directly to the Chief of Department;
Trip:	An ambulance call or run;
Two-Tiered Response:	A response requiring the dispatch of both a BLS and an ALS ambulance;

Uniformed Member:	Personnel holding the following ranks are considered uniformed members of the service: Chief of Department, Superintendent in Chief, Superintendent, Deputy Superintendent, Captain (Principal EMT), Captain (Training Supervisor), Lieutenant (Senior EMT), EMT-Paramedic, EMT-Basic and EMT-Recruit;
Unit:	A response vehicle; e.g., a BLS unit, or Field Supervisory unit; a specialized group such as the Bike Team Unit.

### **Duties and Responsibilities**

The following is a summary of the duties and responsibilities of some of the job descriptions within the Department.

#### **Boston EMS EMT-BASIC**

The Emergency Medical Technician-Basic is responsible for providing emergency treatment of ill or injured persons, and the safe and efficient transport of patients to the appropriate receiving facility. The EMT-Basic's duties and responsibilities include:

- Performs a daily routine checkout of ambulance equipment and supplies and does routine vehicle maintenance; completes records and reports as required;
- Responds safely and promptly to all calls as directed by Dispatch Operations; operates communications equipment in accordance with protocols and procedures. Upon arrival at the scene of an emergency, makes an immediate survey of the situation to determine the need for additional units and reports the status of the incident to Dispatch Operations;
- Directs the efforts of First Responders involved in patient care, and assumes responsibility for patient care until relieved by a ranking clinical member or the receiving facility staff;
- Renders Basic Life Support including the treatment of adult and pediatric injuries and illness; burns; environmental emergencies; cardiopulmonary disorders; abdominal pain; neurologic disorders; obstetrical and gynecological emergencies; communicable diseases; toxicological emergencies; other emergent traumatic and non-traumatic events;
- Initiates CPR to victims of cardiac arrest; requests and assists Advanced Life Support personnel when appropriate; operates the semi-automatic defibrillator and downloads data per established protocol;
- Administers treatment for fractures of all types, and for injuries to the head, face, eyes, neck, spine, chest, abdomen, pelvis, genitalia and other injuries causing bleeding and/or shock; operates mechanical adjuncts to breathing;
- Assists patients in taking their own medications per established protocol; performs rescue tasks to access, assess, stabilize, disentangle, and remove victims of entrapment;

- Cares for emotionally disturbed, alcoholic, drug-influenced, epileptic, and agitated patients in such a manner as to ensure the safety of the patient; manages obstetrical emergencies;
- Assesses each patient, takes vital signs, and records these findings on the patient care report; operates glucometer and administers aspirin per established protocol; completes and submits a patient care report for each response unless the unit is canceled prior to arrival;
- Inspects, cleans, and washes Department vehicles and stations as required; restocks equipment and supplies so as not to fall below par level; operates Department vehicles in a safe and accepted manner;
- Attends training classes and recertification courses as required; maintains a knowledge of all rules and regulations; maintains and updates the policy manual as required;
- Maintains current certification as required per state regulations: EMT certification; Massachusetts driver's license, CPR certification.

### **Boston EMS -PARAMEDIC**

The Emergency Medical Technician-Paramedic is responsible for providing Advanced Life Support skills in accordance with Commonwealth of Massachusetts Statewide Treatment Protocols and applicable special project waiver(s) and for performing Basic Life Support as required. The EMT-Paramedic's duties and responsibilities include:

- Performs a daily routine check out of ambulance equipment and supplies and does routine vehicle maintenance; completes records and reports as required;
- Responds safely and promptly to 9-1-1 calls as directed by Dispatch Operations; operates communications equipment in accordance with established procedure;
- Assumes primary responsibility for patient care at the scene of an emergency; performs Basic Life Support procedures as required;
- Per protocol or under a physician's orders, performs Advanced Life Support procedures including endotracheal intubation; ECG interpretation; defibrillation; synchronized cardioversion; carotid sinus massage; intravenous, intramuscular, subcutaneous, sublingual and endotracheal administration of drugs and/or fluids, chest decompression; intraosseous needle placement; and cricothyrotomy;
- Reports diagnostic information to the medical control physician; continuously monitors the patient condition on scene and enroute to the receiving hospital; updates the medical control physician on any change in patient status;
- Operates Department vehicles as assigned in a safe and accepted manner; inspects, cleans, and washes Department vehicles and stations as required; restocks equipment and supplies so as not to fall below par level;
- Completes and submits a patient care report for each response unless canceled prior to arrival on scene; submits ECG strips or downloads ECG as required;
- Maintains a thorough knowledge of all Advanced Life Support protocols and procedures;
- Maintains a knowledge of rules and regulations; maintains and updates the policy manual as required;

- Maintains certification as required per State regulation: EMT-P certification; Massachusetts driver's license; ACLS certification; CPR certification; attends training classes and rectification courses as required.

### **Boston EMS EMT-TELECOMMUNICATOR**

The EMT-Telecommunicator, under the direction of the Dispatch Operations Supervisor, shall control and coordinate communications on designated EMS channels. In addition to responding to emergencies and providing care, the Telecommunicator's duties and responsibilities include:

- Carries out the orders of the Dispatch Operations Supervisor and the Command Staff;
- Receives, screens, and evaluates requests for service and determines the response requirements per protocol; dispatches, directs, and monitors the movement of all EMS response units; reassigns units to temporary satellite locations;
- Operates radio, telephone, and computer systems, and performs related duties as required; records and relays radio or telephone traffic according to established policy;
- Notifies public safety agencies such as police, fire, Marine and Air Rescue services when the response of such agencies is required; coordinates the response and radio advisories as required;
- Assigns radio channels to be used for medical direction, medical control, consultation, and notification; relays medical traffic and point of entry data as required;
- Directs ambulances, aircraft, and marine units entering the region with critical patients to proper routes, airports, docks, and hospitals;
- Notifies the Dispatch Operations Supervisor or other supervisory staff when administrative or technical problems arise;
- Develops and maintains a thorough knowledge of standard operating procedures including dispatch procedures, call-screening protocols, response areas, and City geography; works as C-MED operator as required;
- Performs related duties as required.

### **Boston EMS LIEUTENANT**

A Lieutenant may be assigned to Field Operations, Dispatch Operations, RTQI, or other assignment as necessary. A Lieutenant is responsible for the clinical and administrative supervision of EMTs, and the administrative supervision of Paramedics in the performance of their duties. In addition to responding to emergencies and providing care, a Lieutenant's duties and responsibilities include:

- Maintains a record of all matters affecting the work shift; maintains a record of responses, vehicle change-overs, and other work activities or significant events;
- Submits a detailed written report as per established policy whenever a complaint is received concerning the performance or conduct of a Department member;
- Submits a detailed written report to the Shift Commander whenever a violation of the rules is observed; investigates complaints and/or reports of vehicle or equipment malfunctions, and takes action to return disabled response units to service;
- Submits a written report to the Shift Commander concerning recurrent false calls; chronic abuse of 9-1-1; conflict between ambulance crew members; conflict between an EMT and a member of another public safety agency, or a member of the public;

- Assumes operational responsibility at the scene of an emergency until relieved by a person of higher rank; provides clinical supervision of EMTs; maintains a thorough knowledge of the multiple casualty incident plans;
- Reviews check-out forms, unit response summaries, motor vehicle accident reports, child abuse reports, elderly abuse reports, and other reports as required; initials each report for the completeness and accuracy; inspects ambulances and equipment for cleanliness; ensures compliance with infection control protocols;
- Reviews patient care reports for completeness and legibility as required;
- Along with the fleet mechanic and with input from the ambulance crew, makes the decision as to whether a unit should be removed from service due to mechanical problems;
- Monitors the driving ability of EMTs assigned to response units; submits a written report to the Shift Commander if negligent or reckless driving is observed and initiates corrective action;
- While assigned to Field Operations, assumes responsibility for one or more geographic divisions; responds to incidents when dispatched; remains in radio contact at all times; monitors the communications of Field units; may be reassigned to Dispatch Operations as required;
- While assigned to Dispatch Operations, directly supervises the performance of EMT-Telecommunicators in using dispatch procedures and call-screening protocols; supervises the operation of C-MED; monitors the response time, on-scene time, and in-hospital time of EMS response vehicles; staffs vacancies in Dispatch Operations Center or Field Operations by reassigning available members from the float pool or by calling overtime in compliance with established policy; updates the Shift Schedule Report and overtime list as required; acts as liaison with the Boston Police Operations Supervisors as required; may be reassigned to Field Operations as required; ensures appropriate notifications are made regarding significant events as per established procedure;
- While assigned to Training and Quality Improvement, supervises the orientation and in-service training of new employees; monitors the progress of new employees during the probationary period; submits written reports as required; assists in continuing medical education programs offered by the Department; maintains records on the certification requirements of all uniformed personnel; participates in continuous quality improvement; may be reassigned to Field Operations or Dispatch Operations as required;
- Performs related duties as required.

### **Boston EMS TRAINING SUPERVISOR / CAPTAIN**

The Training Supervisor / Captain is responsible for the supervision of EMTs, Paramedics, and Lieutenants. In addition to responding to emergencies and providing care, the Training Supervisor's duties and responsibilities include:

- Plans, develops, and implements training programs for EMS, other public safety agencies, other health care providers, and the general public;
- Prepares and conducts continuing education for EMS members;
- Conducts CPR training, CPR instructor training, and CPR recertification training for Department members, other health care providers, and the general public;

- Conducts in-service training on new equipment;
- Develops, plans, and conducts recruit training for all newly hired EMTs;
- Files the necessary forms, documentation and course material for program approval/certification with regional, state or other agencies in compliance with Massachusetts EMT-Instructor/Coordinator requirements;
- Plans and conducts Basic EMT courses as sponsored by the Department; serves as Massachusetts Instructor/Coordinator on Department sponsored EMT programs;
- Assists in planning and conducting training programs in the Department recruitment programs;
- Serves as Field Supervisor or Dispatch Operations Supervisor as assigned. Assumes operational responsibility at the scene of an emergency until relieved by a person of higher rank; provides clinical supervision of EMTs;
- Represents the Department at state and regional committees;
- Performs related duties as required.

**Boston EMS CAPTAIN / PRINCIPAL EMERGENCY MEDICAL TECHNICIAN**

The Captain / Principal Emergency Medical Technician is responsible for the Supervision of EMTs, Paramedics, and Lieutenants. A Captain may be assigned to Special Operations, Dispatch Operations, Professional Standards, or another area of the Department as required. In addition to responding to emergencies and providing care, the Captain's duties and responsibilities include:

- Maintain familiarity with all EMS equipment, operate emergency vehicles and communication equipment;
- Represent the Department in meetings with members of other city agencies, the public, or regulatory agencies;
- Prepare records and reports as required; review records and reports prepared by subordinates for completeness and accuracy;
- Respond to emergencies: serve in the Incident Command System providing supervision as assigned; provide operational supervision at multiple casualty incidents; facilitate patient care, examine, assess, and stabilize patients at emergency scenes;
- Plan, develop, and recommend policies and procedures; interpret, apply and ensure compliance with EMS' policies and procedures;
- Assist in the development and management of systems to receive, investigate and prepare reports on complaints concerning the delivery of emergency services;
- Conduct inspections of EMS personnel, vehicles, and stations for compliance with applicable standards; conduct and investigate internal loss cases, employee conduct, worker's compensation, and related matters;
- Under direction, assists with contracts, billing, and vendor relations for assigned section or area as required;
- Performs related duties as required.

### **Boston EMS DEPUTY SUPERINTENDENT**

A Deputy Superintendent is a member of the Command Staff with authority and responsibility for management of a particular shift, special project, or one or more EMS functions or activities. In addition to responding to emergencies and providing care, a Deputy Superintendent's duties and responsibilities include:

- Implement and oversee departmental policies and procedures to enhance employee performance and insure the effective delivery of emergency medical services;
- Attend meetings with subordinate staff and others to review and discuss operational needs, managerial improvements, and enhancements to policies and procedures;
- Implement programs to document staff performance; prepare and review records and reports of activities performed by subordinate staff; supervise and observe the work of subordinate staff to determine training needs or disciplinary action;
- Conduct investigations as needed; recommend and participate in disciplinary matters as required or directed; insure compliance with operational and/or clinical policies, procedures, and protocols;
- Prepare written materials and presentations;
- Respond to emergency incidents to provide operational or clinical supervisor at mass casualty incidents; assume command of EMS operations and resource deployment until relieved by superior officer;
- Represent the department before the media, civic organizations, the general public and others as directed and authorized;
- Implement and oversee departmental policies and procedures to enhance employee performance and insure the effective delivery of emergency medical services;
- Schedule and when necessary, change work assignments;
- May be required to be part of an on-call manager rotation and be subject to mandatory overtime;
- Perform other duties as required.

### **Boston EMS SUPERINTENDENT**

Under the general or specific direction of the Chief or Superintendent in Chief, in addition to responding to emergencies and providing care, a Superintendent may be assigned any of the following duties and responsibilities:

- Provide direction and leadership on matters related to the management and operation of EMS. Develop, implement, and oversee departmental policies and procedures to enhance employee performance and insure the effective delivery of emergency medical services;
- Provide leadership and direction on operational needs, managerial improvements, and enhancements to policies and procedures;
- Supervise, train, and evaluate subordinate personnel; prepare and implement programs to document staff performance; conduct in-depth analysis of EMS practices and procedures to assess their effectiveness and determine measures for improvements;
- Plan, develop, and conduct management training and operational training and operational training for EMS staff;

- Review and evaluate records and reports of EMS activities; conduct investigations as needed and recommend and participate in disciplinary matters;
- Manage or oversee one or more EMS bureaus or functions; prepare written reports and presentations for EMS and outside entities; represent EMS at public functions and other forums.
- Insure compliance with operational and/or clinical policies, procedures and protocols; respond to emergency incidents and fires and work in hazardous environments as required to facilitate patient care; examine, assess and stabilize patients at emergency scenes; administer treatment, prepare patients for transport, prepare documentation of care received, and transport patients;
- At emergency incidents provide operational supervision and/or command of EMS operations and resource deployment; interact with public safety personnel at incident scenes to insure proper coordination and to enhance pre-hospital patient care;
- May be assigned to serve as a Shift Commander as directed; may be required to be part of an on-call manager rotation and be subject to mandatory overtime;
- Perform other duties as required.

## PART B: Service Zone Planning Process

**105 CMR 170.500 (B)(1)-(5):** Local jurisdictions must develop service zone plans with input from the following entities, at a minimum: first responder agencies operating in the service zone; EFR agencies, if any; all ambulance services providing primary ambulance response pursuant to provider contracts in the service zone; all other ambulance services operating in the service zone; and health care facilities in the service zone, including hospitals and nursing homes.

*Provide a short narrative explaining how the planning and designation process was conducted:*

### Planning Process

While the term “EMS Service Zone” is relatively new, born in the Acts of 2000 MGL Chapter 111c, and CMR 170.000 et seq., delivering out of hospital emergency health care through a comprehensive, integrated plan is not new to Boston.

The high quality, compassionate delivery of pre-hospital patient care in Boston is the result of an evolutionary process that began in earnest in the 1970’s and continues to evolve today. Boston EMS prides itself on constantly updating its practices and techniques to leverage the latest advances in both medicine and technology. In order to ensure both an effective and efficient use of resources, Boston EMS has long sought input and collaboration from our partners in health care; public, private, and non-profit institutions; as well as community and religious groups from across the City. Boston EMS meets with these partners regularly in an unending effort to maximize the quality of emergency healthcare delivered to all of Boston’s residents and visitors. Boston EMS has been evaluated by a number of independent consulting groups including James O. Page; Boston Finance Commission; McGovern Task Force (pre-enabling legislation); and the O’Toole Committee (post-enabling legislation), and is frequently cited in both local and national media for our quality patient care or innovative practices.<sup>1</sup>

This Service Zone Plan for the City of Boston is not a new plan developed in response to the requirements of MGL Chapter 111c, but rather is a snapshot of Boston’s current EMS delivery plan. Boston EMS sent letters to all licensed ambulance services within EMS Region IV inviting their input, and developed an on-line survey for data collection. The service zone planning process was discussed at a number of Regional and Conference of Boston Teaching Hospital (COBTH) subcommittee meetings, and draft versions of the application were distributed to first responder agencies and EMS providers normally operating within the City. The City of Boston continues to welcome input from stakeholders and this Service Zone Plan will be updated accordingly to accurately reflect ongoing changes and refinement in the delivery of EMS services. The EMS Plan includes an inventory of EMS resources and a plan for optimal coordination and utilization of those resources. This plan includes all of the provisions required of a service zone plan and has been developed, and will continue to be refined, with input from our many partners.

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<sup>1</sup> Davis, Robert. “Six Minutes to Live or Die” in USA Today, May 2005. Available on line at: <http://www.usatoday.com/news/nation/ems-main.htm>

### Plan Review and Maintenance

This plan will be reviewed at least annually and [updated](#) whenever significant changes occur. Updated plans will be forwarded to the EMS Regional Council so that the regional service zone plan may be updated accordingly.

### Partner Agencies

Boston EMS supervisory, command, and physician personnel are involved in a number of local, regional, State, National, and even international committees and groups focusing on pre-hospital care and disaster coordination. Listed below are but a few of the groups or agencies with which Boston EMS personnel routinely partner with to ensure a collaborative, progressive, and efficient EMS system in the City of Boston:

Boston Public Health Commission	Boston Fire Department
Boston Police Department	Boston Regional Intelligence Center
Mayor's Office of Homeland Security	UASI Communications Interop Committee
EMCAB Communications Committee	EMCAB Medical Services Committee
COBTH Disaster Committee	Metropolitan Medical Response System
Massachusetts Emergency Management	Statewide Emergency Telecomm. Board
Massachusetts State Police	Suffolk County Sheriff's Office
MassPort Fire Rescue	Massachusetts Ambulance Association
US Dept Homeland Security	United States Coast Guard
Boston MedFlight	US Secret Service
Federal Bureau of Investigation	Drug Enforcement Agency
United States Postal Service	AMTRAK
Institutions of Higher Learning	Boston City Council
MA League of Community Health Centers	Veteran's Administration Medical Services
Faith Based Organizations	Neighborhood Groups
Private businesses throughout City	Boston Fourth of July
Boston Athletic Association	City of Boston Departments
MBEMSC Board of Directors	City of Boston Emergency Control Board
United States Public Health	National Disaster Medical System
Office of the Chief Medical Examiner	Massachusetts Convention Authority
MassHighway	MassGIS
Metropolitan Medical Reserve System	USAO- Anti-Terrorism Advisory Council
Boston Public Schools	First Night
United States Navy	American Red Cross
USPHS	Boston MRC
HHS Region 1	Boston Media outlets
Center for Disease Control	CISM On-Site Academy
AED Partner Agencies	American Heart Association
Massachusetts Hospital Association	National Association of EMS Physicians
Boston Transportation Department	Fidelity Investments
NYC-DOHMA	FDNY-EMS
EMCAB MCI Committee	Pre-Hosp. System Coordination Committee

**B (2) a Elected State / Local Officials**

<b>Mayor</b>	
<a href="#"><u>Thomas M. Menino</u></a>	
<b>City Council</b>	
Salvatore LaMattina, D1 Bill Linehan, D2 Maureen Feeney, D3 Charles Yancey, D4 Rob Consalvo, D5 John Tobin, D6 Chuck Turner, D7	Michael P. Ross, D8 Mark S. Ciommo, D9 John R. Connolly, At-Large Stephen J. Murphy, At-Large Felix G. Arroyo, At-Large Ayanna Pressley, At-Large

**B (2) b Emergency Management**

Name of Entity	Contact Person	Title	Telephone
MOHS	Don McGough	Director	617-635-3351
MOHSEM	LT Phil McGovern	EMS Liaison	617 343-2413

The Mayor’s Office of Homeland Security and Emergency Management (MOHSEM) is located on Bragdon Street in Jamaica Plain. Formerly known as the Boston Emergency Management Agency (BEMA), MOHSEM is the City agency charged with preparing for, and coordinating response to, natural and manmade large-scale incidents. Boston EMS currently has a liaison assigned to MOSHEM on a full time basis..

MOHSEM operates and maintains an Emergency Operations Center. This center (similar in function to the MEMA facility in Framingham) is equipped with the information systems and communications infrastructure necessary to coordinate the response to incidents by the City’s many departments, including public safety, public health and public works agencies.

MOHSEM is the lead agency for developing and coordinating evacuation plans of all size and scope. Boston EMS is designated as the lead agency for the coordination and management of the medical needs of evacuees both during the active evacuation and at any of the designated Mass Care Facilities.

**B (2) c Law Enforcement**

As noted in the “partner agency list”, representatives from Boston EMS work with a number of law enforcement agencies on a regular basis. Clearly, our most frequent contact is with the Boston Police Department, but we also work closely with the Massachusetts State Police, Transit Police, police departments from the various colleges and universities within the City of Boston, as well as Environmental Police, AMTRAK Police, and Federal agencies such as the Federal Bureau of Investigation (FBI), Drug Enforcement Agency (DEA), and Immigration and Custom Enforcement (ICE).

Boston EMS and the Boston Police Department share the same Medical Director. BEMS provides medical support for police officers during law enforcement actions such as high-risk warrant apprehension, barricaded suspect incidents, bomb disposal and chemical lab mitigation. BEMS also has members assigned to work with the BPD Harbor Unit. Members of the BEMS and BPD Command Staffs meet frequently to develop action plans and coordinate coverage for special events. Since 2007, Boston EMS has had a full-time dedicated presence at the BPD's Boston Regional Intelligence Center (BRIC). This partnership allows EMS to maintain an up-to-date awareness of public safety and homeland security issues as well as disseminate any relevant emergency medical information to the EMS, public health and medical community.

BEMS and the BPD conduct joint training exercises. Members of the BPD Special Operations Division provide training to BEMS members in a wide range of areas including working with the explosive ordnance unit, crime scene management, tactical responses, sexual assault, and gang violence. In addition, Boston EMS' DelValle Institute for Emergency Preparedness provides a wide range of hazardous material training for the BPD and other metro area law enforcement agencies.

BEMS works closely with the MBTA Transit Police as well as the Massachusetts State Police (MSP) in day to day operations, as well as providing medical support for their operations when requested. Members of BEMS train with certain elements of the MSP for special events, such as the Democratic National Convention. The BEMS training division conducts training with both the Transit Police and MBTA operations.

BEMS members frequently provide EMS coverage for protective packages associated with visits from the President, Vice President, and visiting dignitaries when requested by the U.S. Secret Service. BEMS provides EMS support for the FBI, DEA, United States Coast Guard and other federal agencies upon request.

**B (2) d Designated Primary Ambulance Service**

Name of Entity	Contact Person	Title	Telephone
Boston EMS	Jim Hooley	Chief	617 343-2367

**B (2) e Other Ambulance Services Providing Primary Ambulance Service**

A number of ambulance services operate in and around the City given our large number of nursing homes, health care facilities, and hospitals. Boston EMS has a close working relationship with many of these agencies through our involvement in local and regional committees, Massachusetts Ambulance Association, Metropolitan Boston Homeland Security Region (UASI), and our back-up agreements with several private ambulance providers. The list of ambulance services providing primary ambulance service within the service zone will be updated ([Part D of Plan](#)) as EMS providers provide notice of their provider contracts in accordance with 105 CMR 170.248 ("Notification of Provider Contracts to Respond to Emergencies").

**B (2) f Designated EMS First Responder (EFR) service, if any**

Name of Entity	Contact Person	Title	Telephone
< no EFR at this time >			

**B (2) g Other First Responder Agencies**

Name of Entity	Contact Person	Title	Telephone
Boston Fire Dept.	Roderick Frazer Ronald Keating	Commissioner Chief .	617 343-3610
Boston Police Department	Edward Davis Daniel Linskey	Commissioner Supt. In Chief	617 343-4500
Massachusetts State Police	<a href="#">Troop E, F, and H</a>		
MassPort Fire Rescue	Robert Donahue	Chief	617 561-3400
Transit Police Department	Paul MacMillan	Chief	617 222-1222

**B (2) h Hospitals**

As the contracted provider of CMED services for EMS Region IV, Boston EMS works cooperatively with the Metropolitan Boston EMS Council office and hospitals throughout the region. Boston EMS personnel are involved with SURGE and Disaster Planning with hospitals, diversion task forces, Mobile Decontamination Unit (MDU) Deployment policy and procedures, and various regional and statewide committees. A complete list of area hospitals and contact information is included in [Part E](#) of the application.

**B (2) I Other Health Care Facilities, Including Nursing Homes**

Boston EMS personnel routinely respond to other health care facilities, including dialysis centers, private physician's offices, laboratories, nursing homes, jails, clinics, and other health care facilities. BEMS personnel are frequently involved in evacuation planning at these facilities, "table-top" exercises, and other EMS related or unusual occurrence planning. A complete list of health care facilities and contact information is included in [Part E](#) of the application.

## PART C-1: Provider Selection / Performance Standards

105 CMR 170.510 (B): Please describe the selection process the service zone has for selection and changing of EMS service delivery or designated service zone providers. This must be an open, fair, and inclusive process.

### **EMS Primary Provider Designation**

Boston EMS is one of six bureaus within the Boston Public Health Commission. The BPHC is a public authority that serves as the City's board of health and is governed by a seven-member board appointed by the Mayor. The BPHC was established pursuant to Chapter 147 of the Acts of 1995 of the General Court of the Commonwealth of Massachusetts, also referred to as the "Enabling Act", and is responsible, among other things, for providing or arranging for the provision of emergency medical service and other public health programs and activities.

"Whereas the Consolidation Agreement provides that the City and the Commission will enter into a contract with the Corporation pursuant to which the Corporation will be the sole provider of EMS services on behalf of the City and the Commission and will use the personnel employed by the Commission in its Boston EMS unit ("Boston EMS") to provide such EMS services". Changing the EMS service delivery or designated service zone provider shall be in accordance with all applicable regulations, agreements, and service zone plans.

EMS services to be provided will include:

- a) Providing emergency medical response for all geographic areas within the City of Boston, including but not limited to Massport, Metropolitan District Commission, and State and Federal Properties. Such emergency medical response coverage shall include responding to:
  - a. 9-1-1 emergency calls in the City of Boston;
  - b. Boston Police and Fire Department stand-bys;
  - c. Boston Police Bomb Squad stand-bys;
  - d. Boston Police Harbor Patrol;
  - e. Logan Airport Stand-bys;
  - f. Decontamination of patients in hazardous materials waste situations;
  - g. Presidential and heads of state stand-bys (VIP Protection details);
  - h. Environmental emergencies, including but not limited to heat, cold, snow, hurricanes;
  - i. Major public events including but not limited to parades, concerts, Fourth of July, First Night, Boston Marathon, Caribbean and Puerto Rican Festivals;
  - j. Mass casualty incidents;
  - k. U.S. Public Health Service, National Disaster Medical Systems; and
  - l. Mutual aid to other cities and towns.
- b) Providing emergency medical support and training for all Federal public safety agencies in the City of Boston, including but not limited to ATF, FBI, US Secret Service, DEA, INS, Department of Defense, State Department, FAA, NTSB, NHTSA, White House Medical, Federal Protective Services, Department of Interior, and US Coast Guard;

- c) Pre-planning for medical emergencies in high rise buildings, in high occupancy apartments, including but not limited to Prudential Center Complex, John Hancock, and Federal Reserve Bank;
- d) Providing emergency medical support and training for the Boston business community, including but not limited to hotels and convention centers;
- e) Providing emergency medical support and training to MBTA, Amtrak, Conrail, MassPort Fire Department, Boston Fire Department, Boston Police Department, Suffolk County Sheriff's Department, Massachusetts Highway Department, and the Central Artery / Third Harbor Tunnel project;
- f) Providing community education and public relations services, including but not limited to schools, health fairs, senior centers, EMT and Paramedic certificate courses;
- g) Providing emergency medical call answering and dispatch services for the City of Boston; and
- h) Providing CMED (i.e. ambulance to hospital communications and inter-hospital communications for EMS) for the City of Boston.”<sup>2</sup>

**105 CMR 170.510(C):** Local jurisdictions must set the following EMS performance standards in their service zone plan. These are the criteria for the selection of service zone provider(s). Potential service zone providers must be evaluated on their ability to meet these local standards. Performance standards must meet minimum standards set forth in the EMS regulations, where applicable. Standards include:

1. response time
2. staffing requirements
3. deployment of resources
4. adequate backup
5. level of service and level of licensure of designated service zone providers
6. medical control
7. appropriate health care facility destinations
8. any other EMS performance measure on which the local jurisdiction(s) wish to set standards and use as selection criteria for EMS providers

### **Response Times: Overview**

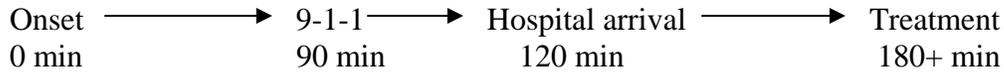
One of the most commonly cited public safety performance indicator is that of “response time”. Since much of this section of the service zone planning template deals with response time, it would be helpful to first clarify some terms as well as highlight recent trends in the literature regarding response times and emergency response.

The EMS system response time makes up a portion of the true total response time. It is important to look at response time from the perspective of the patient: beginning with the onset of illness or injury until the beginning of definitive care. The American Heart Association has reported that there is often a significant delay between the onset of symptoms in the case of an

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<sup>2</sup> Consolidation Agreement between the City of Boston and University Hospital, Inc.

acute myocardial infarction or stroke and the notification of the EMS system.<sup>3</sup> Given frequent emergency room overcrowding, there may also be a delay in the provision of definitive care even after arrival at an emergency room.<sup>4</sup> An onset-to-treatment timeline in an urban setting may look something like this:



In this example, the time from onset of symptoms to definitive treatment is approximately three hours. In addition to striving to minimize the intervals that make up the typical EMS components (9-1-1 call receipt, call entry, call dispatch, turn-out time, travel time, on scene time, transport time, etc.), Boston EMS has long sought to reduce the time segments outside of our direct control as well. For example, Boston EMS has participated in public service campaigns and public education in an effort to make people more aware of the symptoms of acute, life threatening illness and to encourage activation of the EMS system as soon as possible (thus reducing the onset to notification interval). Boston EMS has also pioneered the rapid assessment and recognition of truly time sensitive emergencies (i.e. cardiac emergencies and strokes). The Department also instituted modified point of entry plans and began providing an early notification to receiving hospitals, both of which have lead to a significant reduction in “door to therapy” time. Boston EMS has been a leader in the treatment of trauma, STEMI, stroke, and other time sensitive emergencies. Boston EMS uses emergency medical dispatch protocols to identify patients who are in need of immediate intervention, and rapidly dispatches the appropriate resources, including first responders. In many instances (bronchospasm, pulmonary edema, myocardial ischemia, narcotic overdose, and COPD) the definitive treatment is initiated on scene, drastically reducing the time from onset of symptoms to treatment. In other situations EMS personnel recognize the need for expedited on scene treatment and transport to the definitive time sensitive treatment as described above, again reducing the onset of symptoms to treatment time.

The often-cited response time standard of four minutes for first responder / Basic Life Support, and eight minutes for Advanced Life Support is based on a very specific study that evaluated the outcome of patients who had suffered out of hospital (non-trauma related) cardiac arrest.<sup>5</sup> Using those same response time standards for all types of incidents, no matter how relatively minor, is not only costly to maintain, but unlikely to improve patient outcomes. In its position paper “Considerations in Establishing Emergency Medical Services Response Time Goals”, the National Association of EMS Physicians states:

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<sup>3</sup> See the American Heart Association’s “Act in Time” program; available online at: <http://www.nhlbi.nih.gov/actintime/index.htm>

<sup>4</sup> DPH Advisory Letter: “Management of Emergency Patients Awaiting Admission” Jan 6, 2005. Available online at: [http://mass.gov/dph/dhcq/pdfs/emergency\\_department\\_mang.pdf](http://mass.gov/dph/dhcq/pdfs/emergency_department_mang.pdf) or Massachusetts College of Emergency Physicians: “Health Care in Crisis”. January 25, 2004. Available online at: <http://www.macep.org/attachments/crisis.pdf>

<sup>5</sup> Eisenberg MS, Bergner L, Hallstrom A. “Cardiac Resuscitation in the Community. Importance of Rapid Provision and implications for Program Planning”. JAMA 1979; 241: 1905-7. Abstract available on-line at: <http://jama.ama-assn.org/cgi/content/abstract/241/18/1905>

Except for cardiac arrest, there is little or no scientific evidence suggesting a causal relationship between response interval and improved patient outcomes. There is little evidence linking improved response time intervals to improved survival in critical trauma, and there is no literature suggesting that rapid response intervals improve outcome for non-critical patients. However, there is a public expectation that when EMS is requested, an ambulance will appear within a reasonable time no matter what the complaint.<sup>6</sup>

There is a growing realization in public safety and emergency medicine that except for a small subset of calls, “faster” isn’t necessarily “better”. Driving with emergency lights and siren in operation is not without risk, both to the public and to the responders themselves.

There is risk associated with the use of warning lights and siren: emergency medical vehicles running “hot” (with lights and siren) have been involved in many collisions that have resulted in injuries and death in a high number of cases. The monetary loss derived from emergency vehicle collisions, including property damage, increased insurance premiums, and liability payments in some venues, have eclipsed that of any other negligence-related EMS problem. This situation exists at a time when published data demonstrating the use of lights and siren in response or patient transport is effective in improving patient outcome is lacking.<sup>7</sup>

A number of EMS systems, including Boston EMS, use a system of call triage to prioritize calls for service called emergency medical dispatch (EMD). EMD programs are intended to quickly identify high priority, life threatening illnesses or injury and immediately send appropriate resources. Non-life threatening calls receive a lower priority response, which in some systems results in a response without emergency lights or siren. Boston EMS, in conjunction with the Medical Director, constantly evaluates its call-taking and dispatch criteria. For example, after an evaluation found that a high percentage of motor vehicle collisions reported with “unknown injuries” resulted in no need for ambulance transport, Boston EMS modified its dispatch criteria. Instead of automatically dispatching an ambulance to a reported low-speed vehicle crash with no confirmed injuries, the ambulance is left available to respond to other simultaneously occurring emergencies while awaiting an update from responding police or fire units. This has resulted in a significant reduction in the number of EMS responses without a negative impact on patients who might subsequently require EMS intervention. This is just one of the many innovative management initiatives Boston EMS has implemented to ensure not only an efficient, but safe and fiscally responsible delivery of high quality pre-hospital care throughout the City of Boston.

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<sup>6</sup> National Association of EMS Physicians Position Paper: Considerations in Establishing Emergency Medical Response Time Goals” Available on-line at: <http://www.naemsp.org/Position%20Papers/considerations.pdf>

<sup>7</sup> Joint Position Statement of the National Academy of EMS Physicians and the National Association of State EMS Directors. “Use of Warning Lights and Siren in Emergency Medical Vehicle Response and Patient Transport”. Published in Prehospital and Disaster Medicine, April-June 1994. Available on-line at: <http://www.naemsp.org/Position%20Papers/WarnLghtSirn.html>

## Response Time: Definitions

Recognizing the variety of methods used to collect and/or report response time information, the Metropolitan Boston EMS Council (EMS Region IV), through its Service Zone Planning Advisory Committee, and the Massachusetts Office of Emergency Medical Services have identified several data points and definitions for use by Service Zone planners.<sup>8</sup> The following chart lists each data point, its definition, and how the information is collected by Boston EMS:

<i>PSAP Call Date/Time</i>	
Definition	The time the phone rings (9-1-1 call to public safety answering point or other designated entity) requesting EMS services.
Collection Method	When the 9-1-1 call is received from the 9-1-1 trunk and Meridian switch, the VESTA server logs the ANI/ALI data along with the date/time stamp, retrievable through MAGiC, the 9-1-1 data system. As VESTA routes the call to a call-taker position, the ANI/ALI data is transferred to the Computer Aided Dispatch System (CAD) when ANI/ALI is imported and logs the data along with a date/time stamp (RECEIVE_DT), and appends this to the incident history when created. Calls transferred to EMS will show the time the EMS Calltaker received the call (Received_DT). CAD data is retrievable via the CAD Live Oracle and MIS SQL databases.

<i>Dispatch Notified Date/Time</i>	
Definition	The time dispatch was notified by the 9-1-1 call taker (if a separate entity).
Collection Method	Upon incident entry, CAD logs an entry date/time stamp (ENTRY_DT) and routes the incident to the appropriate dispatch terminal based on the controlling dispatch group for the location and/or incident.

<i>Unit Notified by Dispatch Date/Time</i>	
Definition	The time the responding unit was notified by dispatch.
Collection Method	When the EMS dispatcher assigns the incident to selected unit(s), CAD logs a dispatched date/time stamp (DISP_DT) and routes the incident history information to the dispatched units (when equipped) via the mobile data system.

<i>Unit Enroute Date/Time</i>	
Definition	The time the unit responded; that is, the time the vehicle started moving.
Collection Method	When unit(s) go enroute (via MDT status button directly, or dispatcher CAD command), CAD logs a date/time stamp (ENRTE_DT).

<i>Unit Arrived on Scene Date/Time</i>	
Definition	The time the responding unit arrived on scene; that is, the time the vehicle stopped moving.
Collection Method	When unit(s) go on scene (via MDT status button directly, or dispatcher CAD command), CAD logs a date/time stamp (ONSCENE_DT).

<sup>8</sup> "Response Time and Service Zone Planning". Available at:  
[http://www.mass.gov/dph/oems/forms/service\\_zone\\_planning\\_response\\_times.doc](http://www.mass.gov/dph/oems/forms/service_zone_planning_response_times.doc)

## Response Time: Goals

No universally accepted response-time system requirement exists.<sup>9</sup> In urban areas, a commonly used ambulance response time standard is eight minutes and 59 seconds (8:59), 90% of the time. The 8:59 target also appears in a frequently cited National Fire Protection Association recommendation when adjusted to include “turnout time” (60 seconds) and “travel/response time” (480 seconds).<sup>10</sup> When comparing response times, it is important to determine what interval is actually being measured; some systems use “call entry to onscene”, others will use “dispatch to onscene” or even “enroute (physically in the ambulance) to on scene” when measuring response time. A recent Journal of Emergency Medical Services study noted that a majority of services using the < 8:59 / 90% were measuring from dispatch to unit on scene; essentially leaving out the call processing time.<sup>11</sup> Boston EMS uses the interval from call entry to unit on scene to measure its response times. Reporting call entry to unit on scene gives a more accurate representation of the true system response time from a patient’s perspective.

Boston EMS has adopted varying response time goals depending on the relative severity of the reported emergency. For example, incidents categorized through Emergency Medical Dispatch criteria as 1P include reported cardiac arrest, uncontrollable arterial bleeding, airway obstruction, and other truly time-sensitive emergencies. Upon entry into the CAD system, these incidents will be routed simultaneously to police, fire, and EMS dispatcher’s computer screen ahead of all other simultaneously occurring incidents with a lower priority. Priority 1 incidents involve potentially life threatening emergencies such as difficulty breathing, motor vehicle / pedestrian crashes, cardiac related chest pain, etc. Priority 1 and 1P incidents typically generate both a Basic Life Support and Advanced Life Support response, in addition to first responders. Boston EMS measures both the median response time and the fractile response time. Priority 2 incidents tend to be BLS only responses such as orthopedic injury, lacerations with controlled bleeding, abdominal distress, short falls, etc. Priority 3 incidents are non-acute injury or illnesses that, as previously discussed, normally do not warrant a high speed response.

<i>C (1) a: Designated Primary Ambulance Service / System-wide</i>					
Priority	Median Response	Fractile Response		Starting Point	Ending Point
1P	< 5:00	< 8:59	90 %	Call Entry	On Scene
1	< 6:00	< 9:59	90 %	Call Entry	On Scene
2	< 7:00	< 13:59	90 %	Call Entry	On Scene
3	< 8:00	< 14:59	90 %	Call Entry	On Scene

<sup>9</sup> For more on response times, see: Fitch, Jay. “Response Times: Myths, Measurement, and Management”. Journal of Emergency Medical Services, September 2005 p 48. available on-line at: <http://www.jems.com/jems/30-9/13246>

<sup>10</sup> National Fire Protection Agency, NFPA 1710 “Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments, 2001; section 4.1.2.1.1 (1)-(4).

<sup>11</sup> Williams, DM. “2005 JEMS 200 City Survey: A Benchmark for the EMS Industry” Journal of Emergency Medical Services; February 2006;44-101. Available online at: <http://www.jems.com/data/pdf/200-City-Survey-2005.pdf>

Outliers: It should be noted that while a majority of incidents will fall into these response-time goals, a relatively small percentage will not. There are several possible reasons why a response may fall outside of these goals. For example, the incident may occur during a significant snowstorm in the City, making travel to the scene difficult; the patient may be located on a harbor island, requiring transportation to the scene by boat; the patient may be on an inbound plane not schedule to land for 35 or 40 minutes; or the apparent delay be something as simple as the responding crew failing to notify the dispatcher when they initially arrive on scene.

<i>C (1) b: Other Ambulance Services Providing Primary Service</i>				
Type of Incident	Fractile Response	Starting Point	Ending Point	
Immediately Life Threatening	< 9:59 85 %	Call Entry	On Scene	
Potentially Life Threatening	< 12:00 85 %	Call Entry	On Scene	
Non Life Threatening	< 20:00 85 %	Call Entry	On Scene	

In order to track compliance with these response time goals and to modify them as necessary, private ambulance services providing primary service pursuant shall submit response time information on a monthly basis. Response time information should be submitted to [ServiceZone@BostonEMS.org](mailto:ServiceZone@BostonEMS.org) no later than the 10<sup>th</sup> day of each month for the previous calendar month. The response time information pertains to only to medical emergencies at facilities within the City of Boston; it does not apply to routine or scheduled transfers from contracted facilities.

Notes: Immediately Life Threatening: It is anticipated that long term care facilities will call 9-1-1 in the case of an immediately life threatening emergency.

Potentially or Non- Life Threatening: Whereas medical personnel are on scene treating the patient, ambulance services providing primary coverage pursuant to a [service zone agreement](#) do not need to meet the same response time standards established for the primary ambulance service. However, it is expected that if the contracted provider cannot meet the response standards established in the Service Zone Plan, they will notify the primary service to determine if a closer EMS resource is available.

<i>C (1) c: Ambulance Services Providing Back-Up</i>				
Priority	Median Response	Fractile Response	Starting Point	Ending Point
1P	< 6:00	< 8:59 80 %	Call Entry	On Scene
1	< 7:00	< 9:59 80 %	Call Entry	On Scene
2	< 8:00	< 13:59 80 %	Call Entry	On Scene
3	< 9:00	< 14:59 80 %	Call Entry	On Scene

Note: Fractile response time standards are slightly modified for ambulance services providing back-up to reflect the additional call processing steps involved in such a situation. The primary ambulance service dispatcher must contact back-up services to determine which service has the closest ETA before the call can be dispatched. Steps are ongoing to address this situation and lessen their impact, at which time response time goals may be adjusted accordingly. (See [BAMA](#)). That said, the system wide response time goals (including incidents referred to

ambulance services providing back-up) are noted in the primary ambulance service / system-wide goals.

Whenever an incident is referred to a private ambulance service as part of a back-up agreement, a copy of the completed PCR is to be sent to Boston EMS at [PCR@BostonEMS.org](mailto:PCR@BostonEMS.org) for quality assurance purposes. The patient’s name and the cremembers names may be redacted from the report, but all other incident details- including response times (call receipt, dispatch, on scene, enroute hospital, at hospital, disposition) should be included.

<i>C (1) d and e: EFR / First Responder Agencies</i>				
<b>Priority</b>	<b>Median</b>	<b>Fractile Response</b>	<b>Starting Point</b>	<b>Ending Point</b>
1P or 1	< 4:00	< 6:00 90 %	Call Entry	On Scene

## PART C-2: Service Zone Standards

Please indicate what service zone standards are in place for each designated service zone provider; designated primary ambulance service, ambulance services with provider contracts, and EFR(s). Service zone standards must meet all applicable EMR regulatory standards. Relevant regulatory citations are indicated, where applicable, at the end of each subsection heading.

### **Staffing Requirements [170.305]**

Boston EMS will maintain adequate number of EMS personnel to staff EMS vehicles to ensure compliance with the requirement of 105 CMR.385 (“Service Availability and Backup”) and to carry out its responsibilities under the Boston Service Zone Plan.

Whenever an ambulance operating within the service zone pursuant to a provider contract or agreement to provide back-up services transports a patient receiving care at the BLS level, the ambulance will be staffed with at least two EMTs who are at a minimum certified at the EMT-Basic Level.

Whenever an ambulance operating within the service zone pursuant to a provider contract or agreement to provide back-up services transports a patient receiving care at the Intermediate level of ALS, the ambulance must be staffed with a minimum of two EMTs, at least one of whom is certified at the EMT-Intermediate level or higher. The higher level EMT will attend to the patient.

Whenever an ambulance operating within the service zone, pursuant to a provider contract or agreement to provide back-up services, transports a patient receiving care at the Paramedic level of ALS, the ambulance must be staffed with a minimum of two EMTs, both of whom are certified at the EMT-Paramedic level.

Boston EMS will staff its Paramedic units with two Paramedics who are not only certified by The Massachusetts Office of Emergency Medical Services (OEMS) at the EMT-Paramedic level, but who have also successfully completed a Boston EMS training program and have received

authorization to practice from the EMS Medical Director. Boston EMS Paramedic Training units may be staffed by at least one Department Paramedic along with one or two OEMS certified EMT-Paramedics during a field internship.

OEMS may periodically issue Paramedic level staffing waivers during special events, inclement weather, or other situations<sup>12</sup>. The Medical Director of Boston EMS must authorize the use of any staffing waiver for an ambulance service operating within the City pursuant to a provider contract or agreement to provide back-up services.

### **Deployment of Resources**

Boston EMS utilizes a two-tiered response model in which roughly three-quarters of the ambulances in service will be BLS units staffed by EMTs. The balance of the ambulance deployment (approximately one quarter of in-service units) are ALS units staffed by two EMT-Paramedics. Among the 50 largest cities in America, those that save the highest percentage of cardiac-arrest victims -- Seattle, Boston, Oklahoma City and Tulsa -- use such a two-tiered response.<sup>13</sup> Field Supervisors and Field Shift Commanders are equipped with medical equipment and in addition to overseeing the clinical and operational aspects of an incident, are capable of providing EMS First Responder services. [Map]

Boston EMS uses demand staffing, meaning the Department begins to increase the number of available ambulances at 06:00 when the call volume typically begins to rise, and begins to decrease available ambulances at 02:00 when call volume typically begins to decline. Ambulances are strategically deployed around the City in an effort to provide the most efficient use of available resources and demand for services.

Boston EMS also has extensive mutual aid agreements in place with regional EMS providers. In certain situations, emergency calls may be referred to a private ambulance service. In serious cases, or when EMS anticipates a delayed response, first responder agencies are also dispatched to provide first aid, airway support, and defibrillation as needed until the arrival of the EMS unit. This response model has proven to be the most effective system to provide superior medical response to all neighborhoods of the City.

### **Adequate Backup [170.385]**

Adequate backup for ambulance service shall consist of, at a minimum, both first and second backup as defined in 105 CMR 170.385 (A)(3)(a) and (b), and shall meet any additional requirements as required in this Service Zone Plan. Boston EMS maintains written back-up agreements with a number of ambulance services that normally operate in and around the Boston area. See [Part D](#) “EMS and Public Safety Providers” for a list of ambulance services providing back-up to Boston EMS, and [Part F](#) “Inventory of Communications Systems” for a description of Boston EMS Ambulance Mutual Aid (BAMA) Radio.

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<sup>12</sup> CMR 105 170.305 (C)(3) and 105 CMR 170.275(B)

<sup>13</sup> Davis, Robert. “Fewer Paramedics Means More Lives Saved. Study: Constant Use Sharpens Critical Skills”. In USA-TODAY, May 22, 2006. Available on line at: <http://asp.usatoday.com/educate/college/healthscience/articles/20060528.htm>

## **Medical Control [170.300, 170.330(C)]**

Medical control means the clinical oversight by a qualified physician to all components of the EMS system, including and without limitation, the Statewide treatment protocols, medical direction, training of and authorization to practice for EMS personnel, quality assurance and continuous quality improvement.

Boston's three primary public safety agencies- Boston Police, Boston Fire, and Boston EMS-as well as MassPort Fire are all under the oversight of a single Medical Director, thus ensuring standardization of pre-hospital care throughout the City. In addition to the overall oversight provided by the Medical Director, Boston EMS has several other board certified emergency physicians on staff including the citywide toxicologist, and physician oversight of the DeValle Institute of Emergency Preparedness, a division within Boston EMS. Boston EMS also has an Emergency Medicine Fellowship Program for physicians, who play a very active role in ongoing training, quality assurance, and research in the Department. This is clearly evidenced by the number of special project waivers and other research projects originating from Boston EMS. Many of these projects have gone on to become the standard of care across the State. On-line medical control is provided by physicians at the Boston Medical Center, and all Advanced Life Support patient care reports, and a representative cross section of Basic Life Support reports are reviewed by Boston EMS' Research Training and Quality Improvement (RTQI) team and/or physician staff for quality assurance purposes. The planning and data analysis unit prepares management reports for Command Staff, evaluating such things as response times, on scene treatment times, at hospital times, and disposition codes and transport rates. Further, the electronic patient care reporting system allows for more robust and ad-hoc QA reporting of both individual and system wide statistics. For more information on medical control, please see [PART G](#): "Medical Control Plan" of this application.

## **Health Care Facility Destinations [170.020, 170.355]**

Boston EMS and other providers operating within the service zone pursuant to a provider contract or agreement to provide back-up services shall transport patients to an appropriate health care facility in accordance with 105 CMR 170.000: Emergency Medical Services System regulations and an OEMS approved point of entry plan. EMS personnel shall also consider hospital diversion status, special project waivers, and any other applicable regulations.

## **Other EMS Performance Standards Developed by the Service Zone**

### *Incident Management*

The Department of Homeland Security (DHS) issued a National Incident Management System on March 1, 2004, to provide a comprehensive and consistent approach to all-hazard incident management at all jurisdictional levels and across functional disciplines.<sup>14</sup>

A NIMS compliant incident management system will form the basic structure of all Boston EMS emergency operations, regardless of size.

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<sup>14</sup> For more information on NIMS: <http://www.fema.gov/emergency/nims/index.shtm>

### *Interagency Cooperation*

When a Boston EMS unit arrives at a scene at which first responders are present, the assumption of medical responsibility by EMS personnel shall occur as soon as possible. The transition shall be smooth and orderly and any pertinent information, if available, shall be obtained. The Boston EMS crew shall be responsible for releasing first responders from the scene as soon as there is no further need for assistance.

Any dispute between EMS personnel operating within the service zone and members of other public agencies concerning patient care, scene management, or general conduct shall be referred to a Boston EMS Field Supervisor immediately. The Field Supervisor shall obtain the relevant facts from the involved personnel of both agencies, attempt to resolve the dispute, and submit a written report to the Shift Commander before the end of the work shift.

### *Notification of Boston EMS for Unusual Occurrence*

An EMS service operating within the service zone pursuant to a provider contract or agreement to provide back-up services shall notify Boston EMS Dispatch Operations if one of the following situations exists. This list is not meant to be all-inclusive, but rather is a general guideline for incidents warranting Boston EMS notification.

- Homicide, suicide, hostage situation, or other suspicious or unusual incident;
- Question of child abuse or elderly abuse;
- The threat of harm to an EMT on scene; a violent patient or patient requiring restraint;
- An incident requiring a prolonged time on scene (e.g., entrapment, fire, etc.);
- Question of a hazardous material incident; explosive or other incendiary device;
- An EMS Vehicle crash or theft of an EMS vehicle or equipment while operating in the service zone;
- Death or serious injury to an on-duty member of a public safety agency or private ambulance service;
- Any serious burn; gunshot wound, stabbing, or other incident likely to require a Boston Police and/or Boston Fire Department investigation;
- Any potential mass casualty incident or incident requiring a building evacuation (power failure, loss of heat, etc.);
- Any other significant or high profile incident involving an EMS unit within the City of Boston where a Boston EMS Supervisor and/or Command Staff response may be warranted.

### *Mass Casualty Incidents*

Each service whose regular operating area includes all or part of the service zone in which a mass casualty incident occurs must immediately dispatch available EMS resources upon request by the primary ambulance service. (170.355.E)

### *Advertising*

EMS services shall not engage in any advertising that is deceptive or misleading to the public or for services other than those for which it is currently licensed, for which its EMS personnel and EMS vehicles are certified and for which it is placed in services. EMS personnel operating in the

service zone pursuant to a provider contract or agreement to provide back-up services shall not hold themselves out to the public or other public safety agencies as being a member of “Boston EMS”, nor shall they use markings on uniforms, facilities, or vehicles which could reasonably lead a member of the public to believe the individual is a Boston EMS employee, or the vehicle is owned / operated by Boston EMS. (170.305)

#### *Waivers for Special Projects*

Boston EMS shall be notified whenever an EMS service operating in the Boston service zone pursuant to a provider contract or agreement to provide back-up services is granted a special project waiver by the Massachusetts Office of Emergency Medical Services. (170.405)

#### *Emergency Medical Services Sudden Cardiac Arrest Reporting Program*<sup>15</sup>

WHEREAS, the Boston Public Health Commission is committed to the enhancement and expansion of public health services in the City of Boston.

WHEREAS, Boston EMS, a division of the Boston Public Health Commission, has a Sudden Cardiac Death Prevention Program within the City of Boston.

WHEREAS, the primary cause of sudden cardiac death is treatable only if rapid defibrillation is provided.

WHEREAS, since the institution of this program, the cardiac arrest survival rate in the City of Boston has shown marked improvement.

WHEREAS, in an effort to further improve the cardiac arrest survival rates in the City of Boston, it is in the interest of the public’s health, safety and welfare that hospitals provide follow-up information on patients who have received treatment by semi-automatic external defibrillation from emergency medical technicians and first responders.

NOW THEREFORE, the Boston Public Health Commission has determined that it is in the interest of the public’s health, safety and welfare that this regulation be promulgated to further the protections provided by state law.

#### Section I. Definitions

“Boston EMS”: the Emergency Medical Services division, Boston Public Health Commission.

“First Responder”: a person as defined by 105 CMR 171.050.

“Medical Director”: the physician charged with medical oversight of Boston EMS by the Boston Public Health Commission.

“Hospital”: any institution, however named, whether conducted for charity or for profit, which is advertised, announced, established or maintained for the purpose of caring for persons admitted thereto for diagnosis, medical, surgical or restorative treatment which is rendered within said institution and which is licensed by the Massachusetts Department of Public Health pursuant to M.G.L. c.111 section 51.

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<sup>15</sup> Boston Public Health Commission Regulation: “Emergency Medical Services: Sudden Cardiac Arrest Reporting Program” October 12<sup>th</sup>, 2004. Available at: [http://www.bphc.org/board/pdfs/regs\\_cardarrestprt.pdf](http://www.bphc.org/board/pdfs/regs_cardarrestprt.pdf)

“Private First Responder”: a person, other than an EMT working for a licensed ambulance service or a First Responder, as defined by state regulation, who provides defibrillation services to the public in a setting outside a hospital, clinic, skilled nursing facility, health center or physician’s office, within the City of Boston.

## Section II. Reporting requirement

All hospitals that receive patients who have had treatment with a semi-automatic external cardiac defibrillation or other such device by a first responder including, first responder agencies such as the Boston Fire Department, Boston EMS, or a private first responder service, shall report the condition and disposition of the patient, within forty-eight hours of admission, to Boston EMS in a manner and form proscribed by the Medical Director. Upon request by Boston EMS or at such intervals as specified by the Medical Director, the reporting hospital and any subsequent hospital in which the patient receives treatment, shall provide any further information they may have regarding the condition and disposition of the patient.

## Section III. Application

1. This regulation shall not apply to individual household use of SAED or AED as prescribed by a private physician.
2. This regulation shall not apply to use of a semi-automatic external cardiac defibrillation or other such device in a hospital, health center or other clinic licensed by the Massachusetts Department of Public Health, by staff of that facility.

## Section IV. Guidelines

The Executive Director of the Boston Public Health Commission may issue guidelines, setting forth the format and reporting procedures.

## Section V. Enforcement

1. Any person or entity that violates any provision of this regulation may be subject to a fine, not to exceed \$1000.00 per violation.
2. Authority to enforce this regulation shall be held by the Boston Public Health Commission, its subsidiary programs or designees.
3. Any violation of this regulation may be enforced in the manner provided in M.G.L. c.111 §187, by the Boston Public Health Commission, its subsidiary programs or designees.
4. Each violation of this regulation shall be deemed a separate offense.

## Section VI. Severability

If any provision, clause, sentence, paragraph or word of this regulation or the application thereof to any person, entity or circumstances shall be held invalid, such invalidity shall not affect the other provisions of this article which can be given effect without the invalid provisions or application and to this end the provisions of this regulation are declared severable.

## Section VII. Effective Date.

This regulation shall take effect ninety days from the date of enactment.

Authority: M.G.L. c. 111, sec. 31; M.G.L. c. 111, App. secs. 2-6(b), 2-7(a) (1), and 2-7(a) (15)

WHEREAS, the Boston Public Health Act established the Boston Public Health Commission ("Commission") as the board of health for the City of Boston ("City) and to administer, enhance, and expand public health services in the City, including emergency medical services;

WHEREAS, the Boston Public Health Act empowers the Commission to prescribe rules, regulations and policies in connection with the performance of its duties and to adopt, amend and repeal reasonable health regulations not inconsistent with any public health regulation of the Commonwealth of Massachusetts;

WHEREAS, Massachusetts General Laws Chapter 111C governs the provision of emergency medical services throughout the Commonwealth and requires that all cities and towns submit to the Massachusetts Department of Public Health a service zone plan that defines the local EMS resources used and coordinated by the primary ambulance service;

WHEREAS, Boston EMS is the designated primary ambulance service provider for the City of Boston as defined by 105 CMR 170.000 pursuant to a Service Zone Plan as approved by the Massachusetts Department of Public Health;

WHEREAS, Boston EMS is responsible for planning, guiding, and coordinating emergency medical services in the City of Boston, including emergency medical services necessitated by special events in the City of Boston;

WHEREAS, it is in the interest of public health, safety, and welfare that hospitals in the City of Boston provide Boston EMS with health information about patients who received pre-hospital emergency medical services, including but not limited to semi-automatic external defibrillation, in order that the quality and effectiveness of emergency medical services can be evaluated and enhanced;

WHEREAS it is in the interest of public health, safety and welfare that all "Private First Responders" operating in the City of Boston use compatible equipment and follow standardized medical and quality assurance protocols; NOW, THEREFORE, the Commission enacts the following regulation:

#### DEFINITIONS

For Purposes of all sections of this regulation, the terms listed below shall have the following meanings:

"*Acute Care Hospital*" – any hospital licensed under M.G.L. c. 111 § 51 which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by 105 CMR 130.026.

"*AED*"-Automatic external defibrillator.

"*Boston EMS*"- Boston Emergency Medical Services, a bureau of the Boston Public Health Commission.

"*Commission*"- the Boston Public Health Commission.

"*Emergency medical services*" or "*EMS*"- the pre-hospital assessment, treatment, transport, and other services utilized in responding to an emergency or during the transport of patients to appropriate health care facilities.

"*Emergency medical technician*", or "*EMT*"- a person who has successfully completed a full course in emergency medical care approved by the Massachusetts Department of Public Health Office of Emergency Medical Services and who is certified in accordance with 105 CMR 170.000 to provide emergency medical services to sick or injured persons in accordance with the Statewide Treatment Protocols. The term "emergency medical technician" shall include EMT-Basic, EMT-Intermediate and EMT-Paramedic.

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<sup>16</sup> Boston Emergency Medical Services Regulation adopted October 1, 2009. Available at: <http://www.bphc.org/boardofhealth/regulations/Pages/Home.aspx>

*“EMS First Response Service”* - the business or regular activity, whether for profit or not, by a licensed EMS provider, designated as a service zone provider pursuant to Department - approved service zone plan for purposes of providing rapid response and EMS.

*“EMS special event coverage”* - emergency medical services beyond that which the Commission routinely provides that are necessary as a result of a special event. EMS special event coverage is paid for by an organizer under the terms of this regulation.

*“Executive Director”* - the Executive Director of the Boston Public Health Commission.

*“Health information”* - information relating to the physical and mental condition of a patient in any form or media, whether electronic, paper or oral, which is attendant to or arises from the request for transport by Boston EMS.

*“Hospital”* - any institution, however named, whether conducted for charity or for profit, which is advertised, announced, established or maintained for the purpose of caring for persons admitted thereto for diagnosis, medical, surgical or restorative treatment which is rendered within said institution and which is licensed by the Massachusetts Department of Public Health pursuant to M.G.L. c.111 section 51.

*“Organizer”* - any person, organization, or entity that organizes, sponsors, promotes or otherwise plans any special event.

*“Primary ambulance service”* - the designated primary ambulance service for the City of Boston pursuant to a Service Zone Plan as approved by the Massachusetts Department of Public Health pursuant to General Laws Chapters 111C.

*“Private First Responder”* - a person, other than an EMT working for a licensed ambulance service or a First Responder, as defined by state regulation, who provides defibrillation services to the public in a setting outside a hospital, clinic, skilled nursing facility, health center or physician’s office, within the City of Boston.

*“SAED”* - Semi-automatic external defibrillator.

*“Special Event”* -

1. Any event held in the City at which the anticipated attendance is greater than five thousand (5,000) people; or
2. Any event held in the City that requires the organizer to complete a City of Boston Public Event Application, or Film Permitting Request; or
3. Any event held in the City that because of its nature or the activities performed therein may adversely impact public health or the administration of timely and adequate emergency medical services to event attendees or the surrounding public. Examples of special events include, but are not limited to, professional athletic/sports events, performances, exhibitions, concerts, festivals, marches, parades, processions, road races, contests, and film events.

Notwithstanding any provision of this regulation, the term “Special Event” shall not include:

- i. An event held by a governmental agency, including but not limited to events sponsored by the City,
- ii. certain expressive activity protected by the laws of Massachusetts and the United States; or
- iii. An event having an anticipated attendance of less than one hundred (100) people.

## SECTION 1. PLANNING, GUIDANCE, AND COORDINATION OF EMS SERVICES

1. The Commission, through Boston EMS the primary ambulance service for the City of Boston, shall plan, guide, and coordinate emergency medical services for the City under the direction of and at the discretion of the Executive Director pursuant to General Laws Chapters 111 App. §2-1 et seq., 111C and the EMS Service Zone Plan for Boston, Massachusetts as approved by the Massachusetts Department of Public Health.

2. Boston EMS shall coordinate necessary emergency medical services within the City of Boston, which shall include but are not limited to the following:

- a. Service accessibility through the designated emergency telephone numbers;
- b. Telecommunications screening to determine an appropriate EMS response for each call for emergency medical services received;
- c. Pre-hospital assessment, treatment, and transport;
- d. Access to appropriate health care facilities in the City including trauma centers within the City or its neighboring communities;
- e. Planning, coordination and implementation of emergency medical services, including patient tracking, during mass casualty incidents, natural disasters, mass meetings, declared states of emergency and for certain special events;
- f. Development and implementation of protocols for the effective use of SAEDs, including training for the public on defibrillation services;
- g. Establishment of reporting requirements for acute-care hospitals in the City for training and quality assessment and improvement of health outcomes;
- h. Development of a standardized patient data collection system which covers all phases of the EMS system in the City; and,
- i. Periodic review and evaluation of EMS services.

## SECTION 2. SPECIAL EVENT EMS COVERAGE REQUIREMENTS

### **2.1 Purpose**

The Commission enacts the following regulation to establish procedures for determining what emergency medical services are needed for special events in the City and ensuring that such emergency medical services are provided.

### **2.2 Special Event Requirements**

1. An organizer must obtain EMS special event coverage as determined by Boston EMS in accordance with the provisions of this regulation.
2. An organizer must provide written notice to the Commission of the size, nature, duration, location of the event, and any other information regarding the special event as may be required, at least fifteen (15) days in advance of the first day of the special event, unless such notice is waived by the Commission. The Commission may determine the form on which such notice shall be made.
3. Upon notification of a special event, the Commission will determine what, if any, EMS special event coverage is required. If EMS special event coverage is required, the Commission will inform the organizer what EMS special event coverage is required and specify acceptable coverage provider or providers.
4. The organizer must remit to the Commission the required fees for any EMS special event coverage that will be provided by Boston EMS. If any EMS special coverage will be provided by any other

provider or providers, the organizer must submit proof acceptable to the Commission that the organizer has obtained such coverage prior to the event.

5. After the organizer has successfully complied with all applicable provisions of this regulation, the Commission will certify that the organizer has fulfilled the EMS coverage requirements of this regulation for the special event to take place.

6. The Executive Director is hereby authorized to establish fee scales for the issuance of a certification of an event which may vary according to size of the event.

7. Whoever violates any provision of Section 2 of this regulation shall be subject to a fine and the cost of any EMS special event coverage assigned to the event.

### **SECTION 3. REPORTING REQUIREMENTS FOR HOSPITALS**

#### **3.1 Purpose**

The Commission has determined that it is in the interest of the public's health, safety and welfare that hospitals receiving certain patients from the emergency medical system provide certain information to the Commission.

#### **3.2 Sudden Cardiac Death Prevention Program**

1. All hospitals that receive patients who have had treatment with an SAED or other such device by a first responder including, first responder agencies such as the Boston Fire Department, Boston EMS, or a private first responder service, shall report the condition and disposition of the patient, within forty-eight hours of admission, to Boston EMS in a manner and form proscribed by the Boston EMS Medical Director.

2. Upon request by Boston EMS or at such intervals as specified by the Boston EMS Medical Director, the reporting hospital and any subsequent hospital in which the patient receives treatment, shall provide any further information they may have regarding the condition and disposition of the patient.

#### **3.3 Quality Assessment and Improvement Reporting Program**

1. All Acute Care Hospitals in the City of Boston that provide in-patient care and treatment to patients transported by Boston EMS, and any subsequent hospital(s) in which the patient receives further treatment, shall, upon request by the Medical Director of Boston EMS, provide health information regarding the diagnosis, condition and disposition of the patient for purposes of quality assessment and improvement.

2. The provisions of this regulation do not amend, modify or otherwise relieve any hospital of any other regulatory, administrative or statutory reporting requirements.

### **SECTION 4. TRAINING, EVALUATION, EQUIPMENT AND QUALITY ASSURANCE REQUIREMENTS FOR PRIVATE FIRST RESPONDERS**

1. Boston EMS, as the lead agency for the provision of pre-hospital emergency medical services in the City of Boston, shall specify medically appropriate protocols for all Private First Responders.

2. Prior to offering defibrillation services, and at least annually thereafter or at such other interval as is specified by the Boston EMS Medical Director, a Private First Responder must undergo a training evaluation as determined by the Boston EMS Medical Director.

3. A Private First Responder shall utilize cardiac defibrillation equipment which is compatible with or is augmented with plugs and/or adapters such that the equipment is compatible with a defibrillation pad as designated from time to time by the Boston EMS Medical Director.
4. A Private First Responder shall participate in the Boston EMS Quality Assurance Program as determined by the Boston EMS Medical Director.
5. A Private First Responder shall utilize cardiac defibrillation equipment which provides on-site retrieval of the following quality assurance data: 1) time SAED turned on; 2) date; 3) time analysis begun; 4) initial rhythm; 5) time each shock delivered; 6) cardiac rhythm pre and post each shock; and, 7) energy level delivered for each shock. Such information shall be provided to Boston EMS in accordance with its Quality Assurance Program.

#### **4.1 Application**

1. Neither this section nor Section 3.2 of this regulation shall apply to individual household use of SAED or AED as prescribed by a private physician.
2. Neither this section nor Section 3.2 of this regulation shall apply to use of a semi-automatic external cardiac defibrillation or other such device in a hospital, health center or other clinic licensed by the Massachusetts Department of Public Health, by staff of that facility.

#### **SECTION 5. GUIDELINES**

The Executive Director may issue guidelines for the implementation of one or more sections of these regulations, including but not limited to, definitions of terms as used in these regulations and in the guidelines. In the event of a conflict between these regulations and the guidelines, as either may be amended, the regulations shall control.

#### **SECTION 6. ENFORCEMENT**

1. Authority to enforce these regulations shall be held by the Commission, its subsidiary divisions, programs or designees, including Boston EMS, and the City of Boston and its subsidiary departments, offices, or designees.
2. Any violation of this regulation may be enforced in the manner provided in M.G.L. c. 111, § 187, by the Commission, its subsidiary divisions, programs or designees, including Boston EMS.

#### **SECTION 7. SEVERABILITY**

If any provision, clause, sentence, paragraph or word of these regulations or the application thereof to any person, organization, entity or circumstances shall be held invalid, such invalidity shall not affect the other provisions of these regulations which can be given effect without the invalid provisions or applications and to this end the provisions of these regulations are declared severable.

#### **SECTION 8. CONSTRUCTION**

Nothing in these Regulations shall be construed to conflict with any regulation or statute of the Commonwealth of Massachusetts.

#### **SECTION 9. VIOLATIONS**

Whoever violates any provisions or sections of these regulations shall be subject to a fine of not less than one hundred dollars (\$100) nor more than one thousand dollars (\$1,000).

Authority: M.G.L. c. 111, 31; M.G.L. c. 111, App. §§2-1, 2-6(b) and 2-6(j), 2-7(a)(1) and 2-7(a)(15).

### Section 1: Findings and Declaration of Public Interest

- A. The Boston Public Health Commission is committed to the enhancement and expansion of public health services in the City of Boston.
- B. Boston EMS, a division of the Boston Public Health Commission, has developed a Sudden Cardiac Death Prevention Program within the City of Boston.
- C. The primary cause of sudden cardiac death is treatable only if rapid defibrillation is provided.
- D. Since the institution of this program, the cardiac arrest survival rate in the City of Boston has shown marked improvement.
- E. In an effort to further improve the cardiac arrest survival rates in the City of Boston, it is in the interest of the public's health, safety and welfare that the semi-automatic external cardiac defibrillation program be extended to qualified "Private First Responders" as defined below.
- F. It is in the interest of the public's health, safety and welfare to have coordination of all credentialing, evaluation, quality assurance and equipment compatibility under the auspices of the Boston EMS Medical Director.
- G. The Massachusetts Department of Health has established regulations concerning the implementation of semi-automatic external defibrillation programs for emergency medical technicians and First Responders.
- H. It is in the interest of the public's health, safety and welfare that this regulation be promulgated to further the protections provided by state law.

### Section 2: Definitions

- "AED": Automatic external defibrillator.
- "Boston EMS": the Emergency Medical Services division, Boston Public Health Commission.
- "First Responder": a person as defined by 105 CMR 171.050.
- "Medical Director": the Boston Medical Center physician charged with medical oversight of Boston EMS.
- "Private First Responder": a person, other than an EMT working for a licensed ambulance service or a First Responder, as defined by state regulation, who provides defibrillation services to the public in a setting outside a hospital, clinic, skilled nursing facility, health center or physician's office, within the City of Boston.
- "SAED": Semi-automatic external defibrillator.

### Section 3: Training Evaluation, Equipment and Quality Assurance

- A. Boston EMS, as the lead agency for the provision of pre-hospital emergency medical services in the City of Boston, shall provide a Medical Director who may specify medically appropriate protocols for any Private First Responder.
- B. Prior to offering defibrillation services, and at least annually thereafter or at such other interval as is specified by the Boston EMS Medical Director, a Private First Responder must undergo a training evaluation as determined by the Boston EMS Medical Director.
- C. A Private First Responder shall utilize cardiac defibrillation equipment which is compatible with or is augmented with plugs and/or adapters such that the equipment is compatible with a defibrillation pad as designated from time to time by the Boston EMS Medical Director.

- D. A Private First Responder shall participate in the Boston EMS Quality Assurance Program as determined by the Boston EMS Medical Director.
- E. A Private First Responder shall utilize cardiac defibrillation equipment which provides on-site retrieval of the following quality assurance data: 1) time SAED turned on; 2) date; 3) time analysis begun; 4) initial rhythm; 5) time each shock delivered; 6) cardiac rhythm pre and post each shock; and, 7) energy level delivered for each shock. Such information shall be provided to Boston EMS in accordance with its Quality Assurance Program.
- F. This regulation shall not apply to individual household use of SAED or AED as prescribed by a private physician.

#### Section 4: Enforcement

Any person or entity violating this regulation shall be subject to a fine of not less than one hundred dollars (\$100) nor more than one thousand dollars (\$1000) for each day that such violation continues.

[Authority: M.G.L. c. 111, sec. 31; M.G.L. c. 111, App. secs. 2-6(b), 2-7(a)(1), and 2-7(a)(15)]

## PART D: EMS and Public Safety Providers

**105 CMR 170.510 (A):** Inventory of resources available in the service zone. Please complete the following table indicating all EMS providers in the service zone.

### Designated Primary Ambulance Service

Primary Ambulance Service means the business or regular activity, whether for profit or not, by a licensed ambulance service, designated under a service zone plan for the purpose of providing rapid response and pre-hospital EMS, including, but without limitation, patient assessment, patient treatment, patient preparation for transport and patient transport to appropriate health care facilities, in conformance with the service zone plan.

Name of Service	# Ambulances	Contact Person	Phone
Boston EMS	50	Chief Jim Hooley	617 343-2367

### Ambulance Services with Provider Contract

Provider contract means an agreement, written or verbal, with an ambulance service to provide primary ambulance response to facilities with health care professionals on site, or to special events or functions with a dedicated ambulance on site. This definition shall not preclude any other category of provider contract that is recognized by the local jurisdiction in a service zone plan.

Alert		
VA Hospital	WRVA, JPVA	

Action		
none		

AMR Ambulance Service		
none		

Armstrong		
Wingate	100 North Beacon	Brighton
Landmark at Longwood	63 Parker Hill Avenue	Mission Hill
Kindred of Boston	1515 Commonwealth Ave	Brighton
Roscommon on the Parkway	1190 VFW Parkway	West Roxbury
Armenian Nursing Home	431 Pond Street	Jamaica Plain
Daughters of Saint Paul	50 St. Paul Ave	Jamaica Plain
Fenway Park	4 Yawkey Way	Boston

<b>Armstrong</b>		
Boston College	Commonwealth Avenue	Brighton

<b>Cataldo Ambulance Service</b>		
Beth Israel Hospital	330 Brookline Avenue	Boston
Boston Medical Center	818 Harrison Avenue	South End
Children's Hospital	300 Longwood Avenue	Boston
Don Orione Nursing Home	111 Orient Avenue	East Boston
East Boston Neighborhood Hlth	10 Gove Street	East Boston
Massachusetts General	55 Fruit Street	Boston
North End Nursing Home	70 Fulton Street	North End
Spaulding Rehab. Hospital	125 Nashua Street	Boston
TD Bank North Garden	100 Legends Way	Boston

<b>EasCare Ambulance Service</b>		
Bostonian Nursing Home	337 Neponset Avenue	Dorchester
Harborlights Rehab / Nursing	804 East 7 <sup>th</sup> St.	South Boston
Laurel Ridge Rehab / Nursing	174 Forest Hills St.	Jamaica Plain
Marian Manor	130 Dorchester Street	South Boston
Radius Specialty Hospital	59 Townsend Street	Roxbury

<b>Fallon Ambulance Service</b>		
Arbour Hospital	49 Robinwood Av	Jamaica Plain
B.I.D.M.C/East	330 Brookline Av	Boston
B.I.D.M.C/West	185 Pilgrim Rd	Boston
B.M.C.-East Newton St.	75 E Newton St	Boston
B.M.C.-Harrison Ave.	818 Harrison Ave	Boston
Benjamin House	120 Fisher Ave	Mission Hill
Boston Center For Rehab	1245 Centre St	Roslindale
Brigham & Women's Hospital	75 Francis St	Boston
Brighton House	170 Corey Road	Brighton
Carney Hospital	2100 Dorchester Ave	Dorchester
Corey Hill Nh	249 Corey Rd	Brighton
Dana Farber Cancer Institute	44 Binney St	Boston
Deutesch Altenheim N	2222 Centre St	West Roxbury
East Boston Nigh. HC	10 Gove St	East Boston
Elder Services Plan - Boston	2216 Dorchester Ave	Dorchester
Faulkner Hospital	1153 Centre St	Jamaica Plain
Franciscan Children's Hospital	30 Warren St	Brighton
Goddard House NH	201 S Huntington Ave	Jamaica Plain
Hale House NH	273 Clarendon St	South End
Laurel Ridge NH	174 Forest Hills St	Jamaica Plain
Lemuel Shattuck Hospital	170 Morton St	Jamaica Plain
Lindemann Center	25 Staniford St	Boston
Mass Eye & Ear Infirmary	243 Charles St	Boston
Mass General Hospital	1 Fruit St	Boston
New England Baptist Hospital	91 Parker Hill Ave	Roxbury

North End NH	70 Fulton St	Boston
Park Place (H.P. Conv.)	113 Central Ave	Hyde Park
Radius Specialty Hospital	59 Townsend St	Roxbury
Roscommon Extended Care	405 River St	Mattapan
Roscommon of West Roxbury	5060 Washington St	West Roxbury
Roscommon on the Parkway	1190 VFW Parkway	West Roxbury
Sherrill House Nh	135 S Huntington Ave	Jamaica Plain
Solomon Carter Fuller	85 E Newton St	South End
South Cove Manor NH	120 Shawmut Ave	South End
Spaulding Rehabilitation	125 Nashua St	Boston
St Josephs Home	321 Centre St	Dorchester
St. Elizabeths Hosp	736 Cambridge St	Brighton
Stonehedge NH	5 Redlands Rd	West Roxbury
The Boston Home	2049 Dorchester Av	Boston
Uphams Elder Service Plan	1140 Dorchester Av	Boston

<b>Lifeline</b>		
Presentation Manor	10 Bellamy Street	Brighton
Brighton House	170 Corey Road	Brighton

<b>McCall's</b>		
Benjamin Healthcare	120 Fisher Avenue	Roxbury
Standish Village	1190 Adams Street	Dorchester
Bayview	1380 Columbia Road	Dorchester
Kit Clark	1500 Dorchester Avenue	Dorchester
Uphams Corner Health Cntr	415 Columbia Road	Dorchester

<b>Professional</b>		
Harvard Business School	16 North Harvard Street	Brighton
Spaulding Rehab Hospital	125 Nashua Street	Boston

<b>Samaritan Ambulance</b>		
Bayview Assisted Living	1380 Columbia Rd	South Boston
Benjamin Health Care	120 Fisher Avenue	Roxbury
Boston University	925 Commonwealth Ave	Boston
Dr. Alexeyenko Medical Office	219-B Allston Street	Brighton
Dr. Talayevsky Medical Office	1272-74 Hyde Park Ave	Hyde Park
Dr. Vaninov Medical Office	71 Washington Street	Brighton
East Boston Health Center	10 Gove Street	East Boston
Laurel Ridge Nursing Home	174 Forest Hills Street	Jamaica Plain
Parkwell Nursing Home	745 Truman Pkwy	Hyde Park
Susan Bailis Assisted Living	352 Massachusetts Avenue	Boston

## Ambulance Services Providing Back-Up to Boston EMS

Adequate backup for ambulance service shall consist of, at a minimum, both first and second back-up as defined in 105 CMR 170.385(A)(3)(a) and (b), and shall meet any additional requirements of the applicable service zone plan. Boston EMS has written mutual aid back-up [agreements](#) in place with the following services:

Name of Service	# Ambulances	Contact Person	Phone
Action Ambulance	23	Mike Moronka	978 253-2606
Alert Ambulance	48	David Sylvaria	508 674-1143
American Medical Response	178	Brendan McNiff	508 650-5513
Armstrong Ambulance	56	Mark Schofield	781 648-0612
Cataldo Ambulance	76	Ron Quaranto	617 616-1328
EasCare Ambulance	72	George Gilpin	617 740-9200
Fallon Ambulance	72	Patrick S Tyler	617 745-2168
Lifeline Ambulance	31	Jonathon Kulis	617 787-1211
McCall's Ambulance	8	Steve McCall	617 288-7772
Professional Ambulance	13	Bill Mergendahl	617 492-2700
Samaritan Ambulance	16	Anthony Chianca	617 364-2911

### Designated EFR Services

EMS First Response Service (EFR Service) means the business or regular activity, whether for profit or not, by a licensed EMS provider, designated as a service zone provider pursuant to an OEMS approved service zone plan for the purpose of providing rapid response and EMS.

Name of Service	# Vehicles	Contact Person	Phone
<none at this time>			

### Other First Responder Agencies

First Responder Agency means a police department, a fire department, the state police participating in highway patrol, an emergency reserve unit of a volunteer fire department or fire protection district, or the Commonwealth or any of its political subdivisions that appoints permanent or temporary lifeguards. A first responder agency shall not mean a service that is a licensed EFR Service.

Name of Service	# Vehicles	Agency Website
Boston Fire Department	> 100	<a href="#">BFD Website</a>
Boston Police Department	> 700	<a href="#">BPD Website</a>
MassPort Fire Rescue	> 25	<a href="#">MassPort Fire Rescue Website</a>
Massachusetts State Police	> 1000	<a href="#">MSP Website</a>
Transit Police Department	> 100	<a href="#">Transit Police Website</a>

## Others Trained to Provide Emergency Response

It would be difficult to list all of the “others trained to provide emergency response” within the City of Boston. In addition to providing ongoing training and professional development for Boston EMS personnel, RTQI personnel are also involved in teaching EMT classes and mentoring high schools across the City. RTQI also provides CPR/AED training to various groups as evidenced by a list of agencies that have received [AED training](#) through Boston EMS. A number of personnel from private security firms responsible for protecting large numbers of workers (Prudential Security, Fidelity, John Hancock, etc) have taken training through BEMS. Several of these individuals have gone on to successfully resuscitate cardiac arrest victims at their place of employment. The DelValle Institute provides a wide range of training and fit-testing to hundreds of people across the Metro-Boston region. Training includes:

- WMD Protection & Decontamination for Health Care Workers (24 hours)
  - Piloted with MMRS funds; developed in collaboration with COBTH Disaster Committee
  - Meets OSHA standards
  - Offered to 9-city Metro Boston Area
  - Audience includes:
    - Hospital ED safety & security staff
    - Private EMS providers
    - Suffolk County Sheriffs
- Advanced WMD/Hazmat Technician (40 hours)
  - Boston EMS trained pre-DNC
  - Highest standard of training for an EMS service
  - Meets OSHA standards
  - Offered to 9-city Metro Boston Area
  - Audience includes:
    - Public health
    - Inspectional services
    - Police supervisors, Special Operations
- WMD Protection & Decontamination for Law Enforcement (24 hours)
  - Developed in partnership with BPD
  - Offered to 9-city Metro Boston Area
  - Meets OSHA standards
- Annual WMD/Hazmat Refresher (8 hours)
  - Classroom and practical
  - Emerging risks and standards
  - Meets OSHA standards
- Respirator Fit Testing
  - *Quantitative* Fit Testing provided with all practical training courses
  - Trained Boston EMS staff as Fit Test Technicians to build capacity

- Masks tested:
  - AV 2000
  - N 95

### **Ambulance Services with Garage Locations in Boston**

<b>Name of Service</b>	<b># Vehicles</b>	<b>Contact Person</b>	<b>Phone</b>
Alert Ambulance	9	David Sylvaria	508 674-1143
Armstrong Ambulance	56	Mark Schofield	781 648-0612
Boston EMS	50	Richard Serino	617 343-2367
Cataldo Ambulance	19	Ron Quaranto	617 616-1328
Children’s Hospital Boston	1	Michael O’Melia	617 355-8410
EasCare Ambulance	43	George Gilpin	617 740-9200
Fallon Ambulance	72	Patrick S Tyler	617 745-2168
Lifeline Ambulance	9	Jonathon Kulis	617 787-1211
McCall’s Ambulance	8	Steve McCall	617 288-7772
Northeastern University	1	D. Joseph Griffin	617 373-8370
Samaritan Ambulance	16	Anthony Chianca	617 364-2911

### **Automatic / Semi-Automatic Defibrillator Inventory**

The Department of Public Health promulgated amendments to the long term care facility licensure regulations at 105 CMR 150.002(I) that require each nursing facility to put into operation at least one automated external defibrillator (AED) by November 30, 2005.<sup>17</sup> In addition to all long term care facilities in the City, AEDs are also available at hundreds of locations across the City. Public access defibrillation training is an ongoing function at Boston EMS, and Boston EMS maintains a database of the location and type of AED reported to Boston EMS. In the Spring of 2009, Boston EMS implemented an innovative program in which the location of all known AEDs is entered into the Computer Aided Dispatch System. When a caller accesses the 9-1-1 system to report a suspected cardiac arrest, the calltaker will receive a notification that our records indicate an AED is available on the premises. The location information is very specific (eg “second floor hallway next to elevator”). The call taker can then prompt the caller to have someone retrieve the device and will provide instructions on its use until the arrival of trained rescuers.

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<sup>17</sup> Department of Public Health, DHCQ Circular Letter 05-06-449. “Automated External Defibrillators (AED) in Nursing Facilities. Available online at: [http://www.mass.gov/dph/dhcq/cicletter/cir\\_letter\\_0506449.doc](http://www.mass.gov/dph/dhcq/cicletter/cir_letter_0506449.doc)

## PART E: Health Care Facilities

**105 CMR 170.510(A)(5):** As part of the inventory of EMS-related resources, please complete the following table for all health care facilities or facilities with health care capabilities on site within the service zone.

### E (1) Hospitals within the Service Zone

[Arbour Hospital](#)

49 Robinwood Avenue  
Jamaica Plain  
617) 522-4400

[Dana-Farber Cancer Institute](#)

44 Binney Street  
Boston  
617) 632-3000

[Franciscan Hospital for Children](#)

30 Warren Street  
Brighton  
(617) 254-3800

[Hebrew Rehabilitation Center for the Aged](#)

1200 Centre Street  
Roslindale  
(617) 325-8000

[Kindred Hospital Boston](#)

1515 Commonwealth Avenue  
Brighton  
(617) 254-1100

[Lemuel Shattuck Hospital](#)

170 Morton Street  
Jamaica Plain  
(617) 522-8110

[Massachusetts Eye & Ear Infirmary](#)

243 Charles Street  
Boston  
(617) 523-7900

[New England Baptist Hospital](#)

125 Parker Hill Avenue

Boston

(617) 754-5800

[Radius Specialty Hospital Boston](#)

(Formerly Jewish Memorial Hospital and Rehabilitation Center)

59 Townsend Street

Roxbury

(617) 442-8760

[Shriners Burns Institute - Boston](#)

51 Blossom Street

Boston

617) 722-3000

[Spaulding Rehabilitation Hospital](#)

125 Nashua Street

Boston

(617) 573-7000

[Tufts Medical Center](#)

800 Washington Street

Boston, MA 02111

617 636-5000

[VA Boston Healthcare System](#)

150 South Huntington Avenue

Jamaica Plain

(617) 232-9500

## **E (2) All Receiving Hospitals**

### [Beth Israel Deaconess Medical Center](#)

330 Brookline Avenue  
Boston  
(617) 667-7000

### [Boston Medical Center](#)

One Boston Medical Center Pl.  
Boston  
(617) 638-8000

### [Brigham and Women's Hospital](#)

75 Francis Street  
Boston  
(617) 732-5500

### [Caritas Carney Hospital](#)

2100 Dorchester Avenue  
Boston  
(617) 296-4000

### [Caritas St. Elizabeth's Medical Center](#)

736 Cambridge Street  
Boston  
(617) 789-3000

### [Caritas Norwood Hospital](#)

800 Washington Street  
Norwood  
(781) 769-4000

### [Children's Hospital](#)

300 Longwood Avenue  
Boston  
(617) 355-6000

### [Faulkner Hospital](#)

1153 Centre Street  
Jamaica Plain  
(617) 983-7000

### [Massachusetts Eye & Ear Infirmary](#)

243 Charles Street  
Boston  
(617) 523-7900

[Massachusetts General Hospital](#)

32 Fruit Street  
Boston  
(617) 726-2000

[Milton Hospital](#)

92 Highland Street  
Milton  
(617) 696-4600

[Mount Auburn Hospital](#)

330 Mount Auburn Street  
Cambridge  
(617) 492-3500

[Newton-Wellesley Hospital](#)

2014 Washington Street  
Newton  
(617) 243-6000

[Quincy Medical Center](#)

114 Whitwell Street  
Quincy  
(617) 773-6100

[Tufts Medical Center](#)

800 Washington Street  
Boston, MA 02111  
617 636-5000

[VA Boston Healthcare System - West Roxbury Division](#)

1400 VFW Parkway  
West Roxbury  
(617) 323-7700

[Whidden Memorial Hospital](#)

103 Garland Street  
Everett  
(617) 389-6270

List of hospitals within EMS Region IV: <http://mbemsc.org/region/hosp.htm>

**E (3) Affiliate Hospital for Primary Ambulance Service**

Boston Medical Center

One Boston Medical Center Pl.

Boston

(617) 638-8000

**E (4) Designated Specialty Care Hospitals**

<b>Hospital</b>	<b>AT</b>	<b>PT</b>	<b>STR</b>	<b>STMI</b>	<b>Burn</b>	<b>PEDI</b>	<b>OB</b>
Beth Israel-Deaconess - West Campus	<b>X</b>		<b>X</b>	<b>X</b>			<b>X</b>
Boston Medical Center-East Newton Pavilion			<b>X</b>	<b>X</b>			
Boston Medical Center-Menino Pavilion	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
Brigham and Women's	<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>
Carney Hospital			<b>X</b>			<b>X</b>	
Children's Hospital Boston		<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>	
Faulkner Hospital			<b>X</b>			<b>X</b>	
Massachusetts General Hospital		<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
Milton Hospital			<b>X</b>				
Mt. Auburn Hospital			<b>X</b>				<b>X</b>
Quincy Medical Center			<b>X</b>				
St. Elizabeth's Medical Center			<b>X</b>	<b>X</b>		<b>X</b>	
Tufts Medical Center		<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>	
West Roxbury Medical Center			<b>X</b>	<b>X</b>			

Legend

- AT - Adult Trauma
- PT - Pedi Trauma
- STR- Stroke Center
- STMI- ST MI
- BURN- Burn Center
- PEDI- Pediatric capabilities
- OB- Obstetrics

In addition to this chart, the Metropolitan Boston EMS Council (EMS Region IV) has prepared a spreadsheet listing the care capabilities of all hospitals within the region. This spreadsheet is available on the MBEMSC Website at: <http://mbemsc.org/provider.htm>

**E (5) Nursing Homes / E (6) Assisted Living Centers**

**ARMENIAN NURSING & REHAB CENTER**

431 POND STREET  
BOSTON, MASSACHUSETTS 02130  
TELEPHONE: (617) 522-2600

**BENJAMIN HEALTHCARE CENTER**

120 FISHER AVENUE  
BOSTON, MASSACHUSETTS 02120  
TELEPHONE: (617) 738-1500

**BOSTON CTR FOR REH SUBACUTE CRE THE**

1245 CENTRE STREET  
BOSTON, MASSACHUSETTS 02131  
TELEPHONE: (617) 325-5400

**BOSTON HOME, INC. (THE)**

2049-2061 DORCHESTER AVENUE  
BOSTON, MASSACHUSETTS 02124  
TELEPHONE: (617) 825-3905

**BOSTONIAN NURSING CARE & REHAB CTR**

337 NEPONSET AVENUE  
BOSTON, MASSACHUSETTS 02122  
TELEPHONE: (617) 265-2350

**CARNEY HOSPITAL TRANS CARE UNIT**

2100 DORCHESTER AVE - 3RD FLOOR  
BOSTON, MASSACHUSETTS 02124  
TELEPHONE: (617) 296-4000

**COREY HILL NURSING HOME, INC.**

249 COREY ROAD  
BOSTON, MASSACHUSETTS 02135  
TELEPHONE: (617) 734-7138

**DON ORIONE NURSING HOME**

111 ORIENT AVENUE  
BOSTON, MASSACHUSETTS 02128  
TELEPHONE: (617) 569-2100

**GERMAN CENTRE FOR EXTENDED CARE**

2222 CENTRE STREET  
BOSTON, MASSACHUSETTS 02132  
TELEPHONE: (617) 325-1230

**GODDARD HOUSE, A RET & NURSING HOME**

201-205 SOUTH HUNTINGTON AVENUE  
BOSTON, MASSACHUSETTS 02130  
TELEPHONE: (617) 522-3080

**HANCOCK SKILLED NURSING & REHAB CTR**

133 HANCOCK STREET  
BOSTON, MASSACHUSETTS 02125  
TELEPHONE: (617) 265-5220

**HARBORLIGHTS REHAB & NURSING CTR**

804 EAST 7TH STREET  
BOSTON, MASSACHUSETTS 02127  
TELEPHONE: (617) 268-8968

**JORDAN REHABILITATION & NURS CENTER**

125 PARKER HILL AVENUE  
BOSTON, MASSACHUSETTS 02120  
TELEPHONE: (617) 754-5800

**LAUREL RIDGE REHAB & NURSING CENTER**

174 FOREST HILLS STREET  
BOSTON, MASSACHUSETTS 02130  
TELEPHONE: (617) 522-1550

**MARIAN MANOR**

130 DORCHESTER STREET  
BOSTON, MASSACHUSETTS 02127  
TELEPHONE: (617) 268-3333

**NORTH END REHAB & NSG CTR**

70 FULTON STREET  
BOSTON, MASSACHUSETTS 02109  
TELEPHONE: (617) 367-3751

**PARK PLACE**

113 CENTRAL AVENUE  
BOSTON, MASSACHUSETTS 02136  
TELEPHONE: (617) 361-2388

**PARKWELL**

745 TRUMAN HIGHWAY  
BOSTON, MASSACHUSETTS 02136  
TELEPHONE: (617) 361-8300

**POND VIEW NURSING FACILITY**

81 SOUTH HUNTINGTON AVENUE  
BOSTON, MASSACHUSETTS 02130  
TELEPHONE: (617) 277-2633

**PRESENTATION NURSING & REHAB CENTER**

10 BELLAMY STREET  
BOSTON, MASSACHUSETTS 02135  
TELEPHONE: (617) 782-8113

**PROVIDENT SKILLED NURS CTR THE**

1501 COMMONWEALTH AVENUE  
BRIGHTON, MA 02135  
TELEPHONE: (617) 782-8113

**RECUPERATIVE SERVICES UNIT**

1200 CENTRE STREET  
BOSTON, MASSACHUSETTS 02131  
TELEPHONE: (617) 363-8778

**ROSCOMMON EXTENDED CARE CENTER**

405 RIVER STREET  
BOSTON, MASSACHUSETTS 02126  
TELEPHONE: (617) 296-5585

**ROSCOMMON ON THE PARKWAY**

1190 VFW PARKWAY  
BOSTON, MASSACHUSETTS 02132  
TELEPHONE: (617) 325-1688

**ROSCOMMON WEST ROXBURY**

5060 WASHINGTON STREET  
BOSTON, MASSACHUSETTS 02132  
TELEPHONE: (617) 323-5440

**SHERRILL HOUSE, INC.**

135 SOUTH HUNTINGTON AVENUE  
BOSTON, MASSACHUSETTS 02130  
TELEPHONE: (617) 731-2400

**SOUTH COVE MANOR NURSING HOME**

120 SHAWMUT AVENUE  
BOSTON, MASSACHUSETTS 02118  
TELEPHONE: (617) 423-0590

**ST ELIZABETHS MEDICAL CENTER TCU**

736 CAMBRIDGE STREET 7TH FLOOR  
BOSTON, MASSACHUSETTS 02135  
TELEPHONE: (617) 789-3000

**ST JOSEPH NURSING CARE CENTER**

321 CENTRE STREET  
BOSTON, MASSACHUSETTS 02122  
TELEPHONE: (617) 825-6320

**STONEHEDGE CONVALESCENT CENTER, INC**

5 REDLANDS ROAD  
BOSTON, MASSACHUSETTS 02132

**TRANS CARE UNIT @ BOSTON MED CTR**

ONE BOSTON MEDICAL CTR PLACE  
BOSTON, MASSACHUSETTS 02118  
TELEPHONE: (617) 638-5900

**WINGATE AT BRIGHTON REHAB & SN RESI**

100 NORTH BEACON STREET  
BOSTON, MASSACHUSETTS 02134  
TELEPHONE: (617) 787-2300

**E (7) Entertainment Venues**

The City of Boston is the capital of Massachusetts and the cultural center of New England. As such, Boston has many entertainment centers with varying levels of health care capabilities on-site. The larger venues, such as Fenway Park, TD Bank North Garden, The Hynes and Boston Convention and Exhibition Centers, The Bank of America Pavilion, university arenas, and Symphony Hall have dedicated first aid rooms or areas. During some events these areas are staffed with medical personnel, private ambulance service coverage, or Boston EMS detail coverage. Other smaller venues, such as theaters and auditoriums, do not typically hire EMS detail coverage.

Boston EMS is generally aware of events occurring at these venues through the licensing process, and evaluates the impact the event may have on the EMS system, as well as on neighborhood (traffic, etc.). Boston EMS coordinates any anticipated event coverage with the event sponsor and the other public safety agencies.

When Boston EMS is not providing coverage at a venue, and EMS is needed, the venue staff will normally call 9-1-1. Alternatively, a request for service may come from a police officer providing security at the site. The Computer Aided Dispatch system is programmed with a number of “common place” locations both to speed call entry, but also to provide the dispatcher and responding personnel with best access or other site specific information via premise warnings. As described in “Automatic / Semi-Automatic Defibrillator Inventory” in Section D, Boston EMS has added AED information to the special location CAD files so that PSAP personnel can advise a caller reporting a suspected cardiac arrest the location of the nearest AED should one be located in the given facility.

## E (8) Special Events

Any event that is open to the public, such as a carnival, festival, fair, parade, or other outdoor event at which the public will gather is considered a public event. Persons or parties seeking to hold public events within the City of Boston must go through a public event permitting process. This process involves completing a Public Event Application describing the event and listing copies of any contracts for sound, stage, cleaning, security, catering or food services. The application must also include proof of permission from the owner of the property where the event will take place.

Applicants will then meet with the City's Special Events Committee.<sup>18</sup> At the Committee, event organizers have the opportunity to meet with the various City departments from which they will be required to obtain approval to hold the event. The Committee will determine if the event is feasible, and will indicate to the applicant what agency approvals are still required. It is important to keep in mind that event organizers are responsible for applying for and obtaining all the individual permits and certificates from the various City departments needed for an event; merely filing the Public Events Application does not satisfy this obligation.

Boston EMS is a member of the City's Special Events Committee and is therefore aware of all special events that have been approved by the City. Our Special Operations Division works closely with members of the Committee to ensure proper planning takes place in anticipation of the events. For example, Boston EMS will have input on which road may / may not be closed during a parade or other large gathering, and ensures the EMS operational plans do not conflict with any plans generated by other City agencies.

The Boston Public Health Commission has enacted regulations regarding Special Events and EMS coverage within the City of Boston.<sup>19</sup> A "special event" is defined as:

1. Any event held in the City at which the anticipated attendance is greater than five thousand (5,000) people; or
2. Any event held in the City that requires the organizer to complete a City of Boston Public Event Application, or Film Permitting Request; or
3. Any event held in the City that because of its nature or the activities performed therein may adversely impact public health or the administration of timely and adequate emergency medical services to event attendees or the surrounding public. Examples of special events include, but are not limited to, professional athletic/sports events, performances, exhibitions, concerts, festivals, marches, parades, processions, road races, contests, and film events.

Notwithstanding any provision of this regulation, the term "Special Event" shall not include:

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<sup>18</sup> For more information on entertainment licensing process within the City of Boston, go to: <http://www.cityofboston.gov/consumeraffairs/entertainment.asp>

<sup>19</sup> BPHC "Emergency Medical Services Regulation", Adopted October 1, 2009. Available at: <http://www.bphc.org/boardofhealth/regulations/forms%20%20documents/boston-emergency-medical-services-regulations-1009.pdf>

- i. An event held by a governmental agency, including but not limited to events sponsored by the City,
- ii. certain expressive activity protected by the laws of Massachusetts and the United States; or
- iii. An event having an anticipated attendance of less than one hundred (100) people.

#### SECTION 1. PLANNING, GUIDANCE, AND COORDINATION OF EMS SERVICES

1. The Commission, through Boston EMS the primary ambulance service for the City of Boston, shall plan, guide, and coordinate emergency medical services for the City under the direction of and at the discretion of the Executive Director pursuant to General Laws Chapters 111 App. §2-1 et seq., 111C and the EMS Service Zone Plan for Boston, Massachusetts as approved by the Massachusetts Department of Public Health.
2. Boston EMS shall coordinate necessary emergency medical services within the City of Boston, which shall include but are not limited to the following:
  - a. Service accessibility through the designated emergency telephone numbers;
  - b. Telecommunications screening to determine an appropriate EMS response for each call for emergency medical services received;
  - c. Pre-hospital assessment, treatment, and transport;
  - d. Access to appropriate health care facilities in the City including trauma centers within the City or its neighboring communities;
  - e. Planning, coordination and implementation of emergency medical services, including patient tracking, during mass casualty incidents, natural disasters, mass meetings, declared states of emergency and for certain special events;
  - f. Development and implementation of protocols for the effective use of SAEDs, including training for the public on defibrillation services;
  - g. Establishment of reporting requirements for acute-care hospitals in the City for training and quality assessment and improvement of health outcomes;
  - h. Development of a standardized patient data collection system which covers all phases of the EMS system in the City; and,
  - i. Periodic review and evaluation of EMS services.

## SECTION 2. SPECIAL EVENT EMS COVERAGE REQUIREMENTS

### **2.1 Purpose**

The Commission enacts the following regulation to establish procedures for determining what emergency medical services are needed for special events in the City and ensuring that such emergency medical services are provided.

### **2.2 Special Event Requirements**

1. An organizer must obtain EMS special event coverage as determined by Boston EMS in accordance with the provisions of this regulation.
2. An organizer must provide written notice to the Commission of the size, nature, duration, location of the event, and any other information regarding the special event as may be required, at least fifteen (15) days in advance of the first day of the special event, unless such notice is waived by the Commission. The Commission may determine the form on which such notice shall be made.
3. Upon notification of a special event, the Commission will determine what, if any, EMS special event coverage is required. If EMS special event coverage is required, the Commission will inform the organizer what EMS special event coverage is required and specify acceptable coverage provider or providers.
4. The organizer must remit to the Commission the required fees for any EMS special event coverage that will be provided by Boston EMS. If any EMS special coverage will be provided by any other provider or providers, the organizer must submit proof acceptable to the Commission that the organizer has obtained such coverage prior to the event.
5. After the organizer has successfully complied with all applicable provisions of this regulation, the Commission will certify that the organizer has fulfilled the EMS coverage requirements of this regulation for the special event to take place.
6. The Executive Director is hereby authorized to establish fee scales for the issuance of a certification of an event which may vary according to size of the event.
7. Whoever violates any provision of Section 2 of this regulation shall be subject to a fine and the cost of any EMS special event coverage assigned to the event.

### **E (9) Other**

Boston is a large urban center with many unique locations to which Boston EMS may respond in the event of an emergency. These include the Prudential Building, the John Hancock Building, and other high rises, the Nashua Street and South Bay Jails, Logan Airport, municipal and

private schools, universities, cruise ships, the South Postal Annex, MBTA and Amtrak Stations, and more. These special locations may have some healthcare trained individuals on site with capabilities ranging from a traditional school nurse to the Massport Fire Rescue Department.

When a call from one of these locations is received at the PSAP, the CAD recognizes the address as a special location and if available, will provide best access and other venue specific information (i.e. hazardous materials on site, etc.) to both the dispatcher and responding field units.

## **E (10) Health Centers**

### **Boston HealthNet Locations**

#### **Codman Square Health Center**

637 Washington Street  
Dorchester  
617-825-9660

#### **Dorchester House Multi-Service Center**

1353 Dorchester Avenue  
Dorchester  
617-288-3230

#### **East Boston Neighborhood Health Center**

10 Gove Street  
East Boston  
617-569-5800

#### **Geiger-Gibson Community Health Center**

250 Mount Vernon Street  
Dorchester  
617-288-1140

#### **Greater Roslindale Medical and Dental Center**

4199 Washington Street  
Roslindale  
617-323-4440

#### **Harvard Street Neighborhood Health Center**

632 Blue Hill Avenue  
Dorchester  
617-825-3400

**Health Care for the Homeless**

790 Albany Street  
Boston  
857-654-1000

**Martha Elliot Health Center**

75 Bickford Street  
Jamaica Plain, MA 02130  
617-971-2320

**Mattapan Community Health Center**

1425 Blue Hill Avenue  
Mattapan  
617-296-0061

**Neponset Health Center**

398 Neponset Avenue  
Dorchester  
617-282-3200

**Roxbury Comprehensive Community Health Center**

435 Warren Street  
Roxbury  
617-442-7400

**South End Community Health Center**

1601 Washington Street  
Boston  
617-425-2000

**South Boston Community Health Center**

409 West Broadway  
South Boston  
617-269-7500

**Upham's Corner Health Center**

415 Columbia Rd.

Dorchester

617-287-8000

**Whittier Street Neighborhood Health Center**

1125 Tremont Street

Roxbury

617-989-3215

**Boston Health Care-Homeless**

790 Albany Street

Roxbury, , MA 02118

857-654-1000

729 Massachusetts Ave Ste 3

Boston, MA 02118

617-414-7999

**Bowdoin St Community Health Center**

230 Bowdoin Street

Dorchester, MA 02122

617-754-0100

**Brigham and Women's Hospital**

**Brookside Community Health Center**

3297 Washington Street,

Jamaica Plain, MA 02130

617-522-4700

**Southern Jamaica Plain Health Center**

640 Center St

Jamaica Plain, 02130

617-983-4100

**Dimmock Community Health Center**

55 Dimock Street  
Roxbury, MA 02119  
Phone: 617-442-8800

**Fenway Community Health Center**

1340 Boylston Street  
Boston, MA 02115  
617-267-0900

**Greater Roslindale Medical Center**

4199 Washington Street  
Roslindale, MA 02131  
617-323-4440

**Harbor Family Health Center**

37 Devine Way  
South Boston, MA 02127  
617-269-0312

**Harvard Vanguard**

165 Dartmouth St  
Boston, MA 02116  
617-859-5000

**Kenmore**

133 Brookline Avenue  
Boston, MA 02215  
617.421.1000

**Post Office Square**

147 Milk ST  
Boston, MA 02109  
617-654-7000

**West Roxbury**

291 Independence Drive  
West Roxbury, MA 02467  
617-325-2800

**Joslin Diabetes Center and Joslin Clinic**

One Joslin Place  
Boston, MA 02215  
617-732-2400

**MGH**

**MGH Back Bay**

388 Commonwealth Ave  
Boston, MA  
617-267-7171

**MGH Charlestown**

73 High ST  
Charlestown, MA  
617-724-8135

**North End Community Health Center**

332 Hanover Street  
Boston, MA 02113  
Phone: 617-643-8000

**Roxbury Comprehensive Community Health Center**

435 Warren St  
Roxbury, MA 02119  
617-442-7400

**South Cove Community Health Center**

885 Washington St  
Boston, MA 02111  
617-482-7555

**Southern Jamaica Plain Community Health Center**

640 Center St  
Jamaica Plain, MA 02130  
617-983-4100

## PART F: Inventory of Communications Systems

**105 CMR 170.510(A)(8):** As part of the inventory of EMS-related resources, local jurisdictions need to identify emergency medical dispatch and public safety answering points (PSAPs).

### Primary PSAP Identification

Boston Police Department- Operations Section  
 1199 Tremont Street; 4-North  
 Boston, MA 02120

*PSAP Operation by:* **Boston Police / EMS**

PSAP Info	Boston Police Department	Boston EMS
<b>Contact Info:</b>	Deputy Supt. John Daley Commander, Operations Boston Police Department 1199 Tremont Street Boston, MA 02120 617 343-4680 <a href="mailto:DaleyJ.bpd@ci.boston.ma.us">DaleyJ.bpd@ci.boston.ma.us</a>	Deputy Supt. Joseph O’Hare Commander, Dispatch OPS Boston EMS 767 Albany Street Boston, MA 02118 617 343-1400 / 617 343-7243 (fax) O’hare@Bostonems.org
<b>Staffing</b>	Day: 10 Calltaker; 7 Dispatcher Eve: 10 Calltaker; 7 Dispatcher Night: 8 calltaker; 6 Dispatcher	6 Telecommunicator; 1 Supervisor 6 Telecommunicator; 1 Supervisor 5 Telecommunicator; 1 Supervisor
<b>EMD Use</b>	None	All Dispatch OPS personnel trained / certified in APCO EMD

### Primary PSAP Overview

The Boston Emergency Medical Services (BEMS) Dispatch Operations Division is part of the Primary PSAP at Boston Police Headquarters. Emergency calls for assistance are received in a number of ways: wire-line 9-1-1 calls are first answered by a Boston Police call taker and if determined the call is medical in nature, an intra-PSAP transfer connects the caller to the BEMS Telecommunicator; wireless 9-1-1 calls are first answered by one of the Massachusetts State Police PSAPs and if determined the call is in Boston and medical in nature, an inter-PSAP transfer (via dedicated trunks) connects the caller to the BEMS Telecommunicator; ten digit emergency calls are received directly by the BEMS Telecommunicator.

## **Emergency Medical Dispatch**

All emergency medical calls for assistance received at the Primary PSAP are provided Emergency Medical Dispatch (EMD) in accordance with APCO (Association of Public-Safety Communications Officials) and under the authority of the Medical Director for the City of Boston. APCO's EMD Program is compliant with National Highway Traffic and Safety Administration (NHTSA) and American Society for Testing and Materials (ASTM) Standards.<sup>20</sup> EMD includes a question scenario format that first confirms the address of the incident and phone number, and then immediately determines whether the event is potentially life threatening determining whether the patient is conscious, whether the patient is breathing, and whether the patient is breathing adequately. When a call is deemed potentially life threatening, an incident is created in the Computer Aided Dispatch (CAD) System and, based on the type code, simultaneously copied with police and/or fire department first responders. If the "All Callers" questions have ruled out a life threatening emergency, EMD then provides a formatted series of questions, by category of complaint, to help determine the nature of the problem, an associated type code to drive dispatch of the closest, most appropriate unit(s), and pre-arrival instructions to empower the caller to render assistance until help arrives. EMD quality assurance/quality improvement (QA/QI) is regularly performed to ensure consistent performance or identify system issues needing improvement.

## **Computer Aided Dispatch**

BEMS shares a common CAD system with the Boston Police and Fire Departments. Ongoing planning provides type codes that drive joint agency responses when necessary, and when type codes are updated as additional information is received. This way, TYPE codes can be agency specific, can be shared, and can be "aliased" to another agency's specific type code; each agency can determine the code name, plain language description and drive agency specific unit response(s). Unit status changes can be monitored by any given agency, and information updates entered in CAD are automatically provided, as necessary, to responding units of all agencies, providing a common operating picture for multi-agency responses. CAD also supports mobile data for all agencies, with interoperable "data" messaging terminal-to-terminal. Integration of BEMS Automatic Vehicle Location (AVL) information (using Global Positioning System, or GPS location information from the EMS field units) is being integrated with the CAD system to provide dynamic (vs. static post/station location) recommendation of the closest, most appropriate unit(s), presented on a CAD-AVL map display.

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<sup>20</sup> APCO: available online at: [http://www.apcointl.com/institute/emd\\_program.htm](http://www.apcointl.com/institute/emd_program.htm) NHTSA EMD Program available at: <http://www.nhtsa.dot.gov/people/injury/ems/Reorder%20files%20for%20CDRom1.htm> ASTM Standards available online at: [http://www.astm.org/cgi-bin/SoftCart.exe/DATABASE.CART/REDLINE\\_PAGES/F1258.htm?L+mystore+prxi4340+1150828009](http://www.astm.org/cgi-bin/SoftCart.exe/DATABASE.CART/REDLINE_PAGES/F1258.htm?L+mystore+prxi4340+1150828009)

## Secondary / Backup PSAP Identification

Boston Fire Department- Fire Alarm Division  
 59 Fenway  
 Boston, MA 02115

### ***PSAP Operation by: Boston Fire Department***

<b>PSAP Agency:</b>	<b>Boston Fire Department</b>
<b>Contact Info:</b>	John Henderson Superintendent, Fire Alarm Boston Fire Department 59 Fenway Boston, MA 02115 617 343-2060 JHenderson.bfd@ci.boston.ma.us
<b>Staffing</b>	Day (08:00-18:00): 5  Night (18:00-08:00): 5
<b>EMD Use</b>	None

## Evacuation of Primary PSAP Procedure

### **Alternate PSAP / Backup Center**

Boston Fire Alarm, located at 59 the Fenway, serves as the alternate PSAP for the City of Boston. Five additional Answering Position Units (APUs) are located in the main operations area at Fire Alarm and are continuously logged-on and available to receive any alternate routed 9-1-1 calls. An audible tone and visual alarm will activate at Boston Fire Alarm when 9-1-1 alternate routing occurs. A back-up operating center is housed in the basement area of Fire Alarm for receiving re-routed 9-1-1 trunk line calls and dispatching EMS and police units should an evacuation of the Primary PSAP become necessary. The backup center is equipped as follows:

#### Ten (10) Telephone Positions:

- Five (5) 9-1-1 Police Answering Positions
- One (1) Police Duty Supervisor Position
- One (1) Police Clerk Position
- One (1) EMS Supervisor Position
- Two (2) EMS Answering Positions

#### Nine (9) Dispatch Positions:

- Six (6) Police Dispatching Positions
- Three (3) EMS Dispatching Positions

The decision to order an evacuation of the Primary PSAP and begin operating from the back-up center shall be a decision based upon multiple factors and must include coordination by Boston Police, Boston EMS and Boston Fire Department personnel. Even under the best of circumstances, the ability to receive and process requests for emergency service from the back-up center will be limited because of the reduced number of calltaking positions, dispatch capability and support services. It is conceivable that under certain types of equipment failures, the back-up center could be activated on a partial basis. For example, telephone answering could be completed at the back-up center while Citywide Dispatch, CMED and Boston Area Policy Emergency Response Network (BAPEREN) operations continued at the Primary PSAP. Prior to ordering any evacuation, caution should be exercised assuring there are no other reasonable alternatives. Unless there appears to be a clear and present danger to Dispatch Operations personnel, the evacuation order for the Primary PSAP shall include consultation with the following Command Staff and Technical personnel: Superintendent in Chief; Superintendent of Field Services; Superintendent of Field Support, and the Commander of Dispatch Operations.

As soon as it appears an evacuation may become necessary, the Verizon Service Response Center (SRC 1-800-E911 HELP) and Boston Fire Alarm should be notified of the situation and requested to begin preparing for possible activation of the back-up center.

- At least one dispatch qualified EMS Telecommunicator shall be sent to Fire Alarm with a portable radio to prepare to take over dispatch functions. This Telecommunicator does not necessarily have to be sent from Dispatch Operations and may come from a field unit or the administrative office if available.
- Upon arrival at Fire Alarm, the EMS Telecommunicator will be given access to a supervisor CAD workstation (if functioning) on the main floor of Fire Alarm. [CAD terminal FDS03 has been designated for this purpose]. The Telecommunicator shall monitor the EMS incidents and prepare to take control of the EMS CAD group should an evacuation of the Primary PSAP become necessary.
- **BFD:** The senior operator or his/her designee shall open the back-up center and ensure that all Computer Aided Dispatch (CAD) computers are powered and functional. The ACD printers should be turned on and checked for an ample supply of paper. Fire Alarm personnel should not log onto APU units in the back-up center at this time as this may cause alternate routed calls to be delivered to the back-up center, rather than the main operations area upstairs.

### **Non-Emergent Evacuation**

In situations where an evacuation is necessary, but there is no immediate threat to the life-safety of personnel, the following steps should be taken prior to, or in conjunction with, the routine evacuation of the Dispatch Center:

- BPD/EMS: The SRC will be advised to re-route 9-1-1 trunk lines to Fire Alarm (note: this process is estimated to take 10-15 minutes).
- Fire Alarm should be notified of the decision to evacuate and to prepare to handle alternate or re-routed 9-1-1 calls.
- Arrangements should be made to transport personnel to Fire Alarm via BPD and /or EMS units.
- Supervisors should ensure that all CAD and VESTA Terminals are “LOGGED OFF” prior to evacuation. Personnel should take their headsets with them to Fire Alarm.

- EMS: Verizon will be advised to “call forward” the EMS Dispatch Operations administrative numbers to Fire Alarm. Calls will be directed to ring at the EMS Supervisor position in the back-up center.
- An announcement shall be made via Citywide 10 advising units that CMED capabilities will be limited. The CMED operator shall select the “Disaster Group Call” and select “yes” to continue. After transmitting an alert tone, announce “Attention all hospitals, be advised that Metro-Boston CMED is unable to coordinate patch requests at this time. Hospitals are directed to monitor their radios for incoming radio traffic until further notice.” The following Patch groups will then be established:

Base	Channel	Hospitals
14 / VHF	155.280	COBTH Disaster Network
3BSTN	5	MGH, NEMC, BIDH
4WALT	8	NWH, DEACW
6CAMB	2	MNTA, CAMB, SMRVL
7NATK	6	MWF, MWN
9BURL	7	LAHY, WINC
11ROX	3	BMCH, BMCEN, BWE
12SCIT	1	SSH, QUIN, MILT

- Once patch groups have been established, announce “The COBTH Disaster Network has been activated. Hospitals are now configured into their preset patches. Station KIR735, Metro Boston CMED, (operator ID), (time).”
- Adjacent CMEDs, co-users of 155.280, the Director of MBEMSC, and private EMS services should also be notified as time permits.
- The MassPort Fire Rescue Department and the Massachusetts State Police should be advised that 10 digit emergency numbers will be temporarily out of service. Requests for EMS or BPD response should be forwarded through Boston Fire Alarm Emergency 2-way number (617 536-1500).
- The “EVAC” group page shall be transmitted with a notation that the back-up center at 59 The Fenway is being activated.
- The supervisor shall take a portable radio and, if available, a cellular phone. These items shall remain with the supervisor and taken to the back-up site.

**Emergency Evacuation**

If the cause of the evacuation is due to a catastrophic event or other hazardous condition making the Dispatch Center uninhabitable, the BPD and EMS Supervisors will advise their personnel to immediately evacuate the building.

- Should the Supervisor be injured or otherwise unable to fulfill these duties, the most senior Telecommunicator shall be in charge until relieved by a person of higher rank or a more senior Department member.
- Personnel shall be advised to meet in the designated meeting area (the flagpole in front of the building). The Supervisor shall direct personnel to an alternate meeting site if it is determined that the designated meeting site cannot be utilized.

- EMS personnel should assist in the evacuation of any injured employees or wheelchair bound personnel. (See Dispatch OPS SOP 426 “Fire at Dispatch Operations Center”).
- Evacuated personnel should assemble at the meeting location for roll call. In the event any personnel are missing and cannot be accounted for, the supervisor shall immediately notify the incident commander of the person’s last known location or assignment.
- Once the emergency evacuation is complete, any outstanding agency specific tasks outlined in Section 4 (“Non-Emergent Evacuation”) should be completed as soon as possible.

### **Transition to Back-Up Center Operations**

#### **Call Routing:**

- Until the SRC is able to re-direct the 9-1-1 trunk lines, 9-1-1 calls will continue to be sent to the Primary PSAP. How these calls are directed from there will depend on the status of the police calltaker’s VESTA terminals. An audible tone and visual alarm will activate at Boston Fire Alarm when 9-1-1 alternate routing occurs.
- If the police calltakers remained logged-on / ready during the evacuation, 9-1-1 calls will be presented to their terminal. If the call is not answered within approximately 55 seconds, the call will then be sent to a standby APU at Fire Alarm through alternate routing.
- If the police calltakers remained logged on / not ready during the evacuation, the Meridian system will determine calltakers are logged on but none are available. Callers will receive a recorded message to stay on the line and the call will be placed in queue.
- If a 9-1-1 call is placed and there are NO police calltakers logged on to the system, the call will be sent to a standby APU at Fire Alarm via alternate routing.

### **Call Handling Procedures**

- Upon notification that an evacuation of the Primary PSAP is underway, all available personnel at Fire Alarm should be prepared to staff the alternate PSAP positions. BFD personnel should be prepared to receive alternate routed emergency calls over these lines.
- Calls received at one of the standby APUs shall be answered using the greeting “9-1-1, this line is recorded- what is your emergency”.
- At a minimum, the following information should be elicited from every caller: location of the reported emergency; call back number and; type of problem or description of incident.
- The information shall be used to generate a CAD incident using the same TYPE Code system used during normal operations (specifically, BFD call takers should use REQF when entering a request for police services or REQE when requesting EMS). In the event the CAD system is not functioning, calls shall be recorded legibly on cards with one card made out for each agency that will be responding.
- One person should be assigned to monitor the MAARS printers and return any abandoned calls. While the 9-1-1 center receives dozens of abandoned calls each day that often involve “prank calls” from payphones or other non-emergencies, it is especially important under these circumstances to determine whether there was a legitimate call that could not be presented to a calltaking position.
- Because of the limited number of calltaking positions, call-handling procedures may have to be modified in order to ensure calls are processed in an efficient and orderly manner.

Providing complete pre-arrival instructions or responding to lower priority calls may be temporarily suspended. This decision will be made by the supervisory staff on scene and will take into account the number of personnel available to answer calls and call volume.

### **Dispatching**

- It is imperative that a dispatch qualified Telecommunicator arrive at Fire Alarm as soon as possible to assume Citywide dispatch of EMS units. Initially, dispatching may be done by portable radio from the main operations area of Fire Alarm. Depending on the status of the radio equipment at Schroeder Plaza, there may be limited “portable to portable” coverage in some areas of the City, but “portable to vehicle” coverage should be acceptable.
- In the unlikely event that a complete evacuation of the Primary PSAP is necessary before an EMS Telecommunicator has arrived at Fire Alarm, the Dispatch Operations Supervisor or designee shall contact Boston Fire Alarm (343-2880) by cellular telephone and remain in voice contact while enroute to the back-up center. Fire Alarm personnel shall notify the EMS personnel of any EMS related incidents they have received and an EMS unit will be dispatched by EMS Dispatch Operations personnel while enroute to the back-up center.
- Upon arrival at the back-up center, all pending EMS calls should be reviewed and appropriate EMS TYPE Codes assigned using the APCO EMD Guidelines. A roll call of EMS units should be performed to update their status and normal dispatch operations will commence.
- As more EMS Telecommunicators arrive, the EMS Supervisor shall assign them to assist the dispatcher as needed, function as calltakers, monitor MED-4, or move downstairs to begin operating from the back-up Center.
- The telecommunicator assigned to CMED should direct units with Priority 2 or Priority 3 traffic to seek an alternate means of hospital notification (contacting the hospital via cellular phone, going through their own dispatch center or using 155.340 if available). Units with Priority 1 traffic for a hospital with an existing patch (see section 4) should be directed to the appropriate MED channel with instructions to hail the hospital directly. If an existing patch is not available and the unit having Priority 1 traffic has no other means of notification, the CMED operator may provide a brief notification to the hospital via telephone or the VHF disaster radio.

### **Back-Up Center Activation**

- Once a sufficient number of personnel have arrived and radio transmitters and digital logging recorders have been activated by BPD and EMS technical services personnel, calltakers should begin logging onto the APU equipment in the back-up center. As soon as the 9-1-1 trunk line re-routing is accomplished by the SRC, 9-1-1 and 7 digit emergency calls will be presented in the back-up center. These calls can then be transferred, as appropriate to EMS or BFD call taker positions for call entry.
- Note: Even after trunk line re-routing is complete, some 9-1-1 calls will be presented to the APUs located along the wall in the main operations area of Fire Alarm. This is normal and occurs because these APUs are logged on to the primary police call taker queue or agent group. “Logging Off” the APUs in the main operations area will result in all 9-1-1 and 7 digit emergency calls being presented in the back-up center.

## **Restoration of Operations**

When a determination is made by Technical and Command Staff personnel that operations at the Primary PSAP can be restored, the transition from the back-up center to the Primary PSAP will be closely coordinated between all agencies involved.

### **Metro-Boston CMED**

CMED, an acronym for Coordinated Medical Emergency Direction, is a concept initiated in the early 1970's under the Federal Emergency Medical Services System Act of 1973. A CMED Center is a resource organization that provides specialized communications functions for hospitals and ambulances. CMEDS provide a vital role in monitoring EMS communications.

The statewide EMS radio network is comprised of discrete regional radio systems. Each system has the following components: a CMED center, associated ambulance services, hospitals, rescue squads, and municipal agencies. The system is designed to meet local needs but adhere to a common design strategy that will afford compatibility across regional boundaries and the interconnection of systems into the statewide network. Operational and medical communications are primarily accomplished via two-way land mobile radio, which usually operates VHF and UHF channels.

Metro-Boston CMED provides coordination of EMS telecommunications throughout the 62 cities and towns in the metropolitan Boston area that comprise Massachusetts EMS Region IV. The center is located within the Boston EMS Dispatch Operations Center and staffed 24 hours a day with specifically trained EMT-Telecommunicators. Functions of Metro-Boston CMED include:

- Managing EMS channel usage within the region.
- Coordinating channel management with neighboring CMEDs as a part of the statewide network.
- Serving as a clearinghouse for EMS resource status information (e.g., emergency room diversions, loading, bed status, specialty care facilities, ambulances, etc.).
- Monitoring the radio traffic to determine the quantity and quality of transmissions and to detect and resolve outages.
- Providing Command/Control/Communications/Intelligence (C<sup>3</sup>I) functions during mass casualty or disaster responses in cooperation with authorized scene commanders and medical control physicians.
- Coordinating EMS with other public safety agencies through the use of radio channel patch capabilities to link mobile units with hospitals.
- Providing general assistance as requested by any EMS agency in accordance with system procedures.
- Aiding out-of-region ("foreign") ambulances and other EMS units entering or passing through the region.

Since the primary function of the CMED system is linking pre-hospital EMS providers and hospitals for the purposes of medical communications, it is not considered among the tactical interoperable communications options available to the Incident Commander. However, CMED

may be used for Medical Branch Incident Command to request regional assistance such as resource and mutual aid requests, staging and loading coordination, hospital point of entry designation, etc.

## **Metro-Boston Homeland Security Region Interoperability**

### **PURPOSE**

Background: In the aftermath of September 11, 2001, the United States Department of Homeland Security (DHS) initiated the Urban Area Security Initiative (UASI) to address national security issues on a regional basis. UASI identified communications interoperability, the ability of public safety agencies to talk across disciplines and jurisdictions, as a priority for the nation.

The purpose of the Metro-Boston Homeland Security Region (MBHSR) Public Safety Communications Interoperability project is to ensure that MBHSR first responders have the ability to share data and communicate at optimal efficiency, in real time, across jurisdictions and disciplines. Increased communications interoperability enables more effective emergency response during day-to-day operations and large-scale events. The mission of the MBHSR communications interoperability project is to improve regional communications interoperability among first responder agencies and improve the efficiency and effectiveness of the region's overall response capabilities.

Towards that end, the participating agencies have created a Standard Regional Channel Plan for Communications Interoperability that will allow for other regional agencies to transmit and receive on their licensed frequencies. This plan (as modified and agreed to) with associated radio frequencies is to be installed on all portable, mobile and dispatch center radios as appropriate for the purpose of regional communications interoperability. This document allows for that use and defines the frequencies and policy for use.

### **AUTHORITY**

The U.S. Department of Homeland Security designated Boston a *high-threat* urban area in July 2003 as part of the Office for Domestic Preparedness' (ODP) Urban Area Security Initiative (UASI) grant program. As the core city, Boston oversaw the delineation of the region, and created the Boston Mayor's Office of Homeland Security (MOHS) to integrate and manage all homeland security activities. The UASI region was subsequently named the Metro Boston Homeland Security Region and consists of nine jurisdictions: Boston, Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop.

The MOHS led an effort to develop a Strategic Plan for Communications Interoperability that addresses and prioritizes how the MBHSR can enhance interoperable communications capabilities during response to emergency incidents. The development of standard regional channel plans was identified as Initiative 1B in the MBHSR Communications Interoperability 5-year Strategic Plan.

## PRINCIPLES

The Participating agencies will abide by the following principles:

1. That all parties will install or program the entire MBHSR Standard Regional Channel Plan as provided in the MBHSR Standard Code Plug, without changes, on all public safety radios controlled by them that possess the capability to support it and utilize the channel nomenclature.
2. That all participating agencies authorize the emergency use of their licensed frequencies by other MBHSR agencies (parties) as outlined in the MBHSR Standard Regional Channel Plan and according to the Interim Guidelines and any future Standard Operating Procedures promulgated and agreed to by participating agencies.
3. That all participating agencies will utilize their block of assigned radio IDs as put forth by the MBHSR-CIS in consecutive order when possible.
4. That all participating agencies will ensure training on and adherence to the Interim Guidelines and any future Standard Operating Procedures promulgated and agreed to by participating agencies and that they will impose appropriate corrective action on personnel found to be in violation.
5. That all participating agencies will implement radio communications procedures for Communications Interoperability Channels consistent with the National Incident Management System (NIMS) and Incident Command System (ICS), to ensure that effective communications processes and systems exist to support a complete spectrum of incident management activities, to include, but not limited to, the following excerpts from the NIMS Incident Management Communications<sup>21</sup> requirements to:
  - 5.1. Individual Jurisdictions: They will be required to comply with national interoperable communications standards, once such standards are developed. Standards appropriate for NIMS users will be designated by the NIMS Integration Center (NIC) in partnership with recognized standards development organizations (SDOs).
  - 5.2. Incident Communications: Incident communications will follow the standards called for under the ICS. The Incident Commander (IC) manages communications at an incident, using a common communications plan and an incident-based communications center established solely for use by the command, tactical, and support resources assigned to the incident. All entities involved in managing the incident will utilize common terminology, prescribed by the NIMS, for communications.
6. That all participating agencies will ensure that communications operators at dispatch centers monitor appropriate interoperability calling channels. (e.g. BAPERN 3, Metro Red, UCALL)
7. That all participating agencies will ensure that interoperability-calling channels are monitored at the Incident Command Post on major incidents requiring significant aid from agencies beyond routine local interoperability. (e.g. BAPERN 3, Metro Red, UCALL)

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<sup>21</sup> NIMS Compliance Document, Chapter 5 “Communications and Information Management” ([http://www.fema.gov/txt/nims/nims\\_doc3-5.txt](http://www.fema.gov/txt/nims/nims_doc3-5.txt))

## INTERIM GUIDELINES FOR USE OF MBHSR CHANNEL PLAN

1. Users are only permitted to transmit on channels they have been assigned to by a control point or in the case of no control point, their Incident Commander.
2. All transmission within the standard regional channel plan other than the user's home frequency must use a call sign including city, agency, and user assigned ID.
3. All transmissions on frequencies not controlled by the user's agency must follow the policies and procedures set forth by the channel's control point.
4. Control points may authorize other agencies and their personnel to transmit on their frequencies.
5. Incident Commanders must seek approval from the channel's control point to transmit or allow others to transmit for the purpose of interoperability.
6. Use of any of these frequencies must adhere to the principles of the National Incident Management System and the Incident Command System.

### **Boston Ambulance Mutual Aid (BAMA) Radio**

The Boston EMS Ambulance mutual aid (BAMA) channel is engineered to afford inter-dispatch center communication between Boston Emergency Medical Services and its back-up providers. A UHF multi-site conventional network operating narrow band with analog and encrypted digital communication, BAMA is used to request mutual aid assistance and coordinate the response of additional medical resources. Coverage will be extended within the Metro-Boston Homeland Security Region (MBHSR) to adhere to a design strategy that will afford compatibility across boundaries and allow interoperability with State and Federal systems.

### **MassPort Fire Rescue Communications**

In an effort to improve interagency communication and coordination during a significant incident at Logan International Airport (Logan), MassPort Fire-Rescue frequencies have been programmed in the 800 megahertz radio at Dispatch Operations and several BEMS Command, Supervisory and Special Operations vehicles.

1. The primary purpose of having these radio frequencies available is to ensure that Dispatch Operations and BEMS Supervisory or Command staff personnel responding to an incident at Logan have the ability to monitor situational updates and advisories.
  - 1.1. The MassPort Fire-Rescue talk-groups are identified as follows:

<i>Frequency</i>	<i>Talk Group</i>
1	Emergency 1
2	Emergency 2
3	Calling
4	Fire OPS
5	Fire Ground
6	Fire Training

- 1.2. "Fire Ground" (frequency 5) will be the selected talk group for the radio at Dispatch Operations unless directed to another talk-group by MassPort Fire-Rescue personnel.
- 1.3. The radios in the mobile units are configured to enable the user to "scan" the various talk groups. When responding to an incident at Logan, BEMS units so equipped should select and monitor "Fire Ground" unless directed to another talk-group by MassPort Fire-Rescue personnel.
2. Transmitting on any of these channels by Boston EMS Dispatch Operations personnel should be reserved for replying to the MassPort Fire-Rescue dispatcher (callsign "Logan Fire Alarm") or MassPort Fire-Rescue Incident Commander (callsign "Logan Command")
  - 2.1. The callsign "Boston EMS Dispatch" shall be used when referring to BEMS Dispatch Operations. For example: "Boston EMS Dispatch from Logan Fire Alarm, you may secure from the ALERT 2 incident". "Logan Fire Alarm from Boston EMS Dispatch, acknowledged, securing from the ALERT 2, out".
  - 2.2. While most interagency communications will be handled by the Dispatch Operations Center and Logan Fire Alarm, there may be situations in which "Logan Command" or "Logan Fire Alarm" wishes to speak directly with BEMS Command Staff or Supervisor via radio. For these purposes, Boston EMS personnel shall assume the following callsigns:

Rank / Title	Callsign
Chief of Department	Boston EMS Chief
Supt in Chief or Shift Commander	Boston EMS Command
Division Field Supervisor	Boston EMS Supervisor

- 2.3. Ordinarily, Boston EMS personnel (both field and dispatch) will transmit on MassPort talkgroups only when replying to MassPort Fire-Rescue personnel. If, in the opinion of the EMS user, an emergency situation exists in which a delay in contacting MassPort personnel via landline or other means may be detrimental, the EMS user may initiate radio traffic directly with MassPort Fire-Rescue personnel.
  - 2.3.1. Except for occasional radio testing or training, all incidents of "EMS initiated" radio traffic on a MassPort radio frequency shall be documented and forwarded to the Superintendent in Chief for review to ensure appropriateness. A copy of the incident report shall also be forwarded to the Commander of Dispatch Operations if the radio traffic was initiated by Dispatch Operations personnel.

### **Boston Health Center & Hospital Radio Network**

Boston Metropolitan Medical Response System (MMRS), in conjunction with the City of Boston, established the Boston Health Center & Hospital Radio Network to afford command center communications between the Boston Public Health Commission, affiliated health centers, hospitals, and the Boston Emergency Medical Services (BEMS). Utilizing the City of Boston 800 Mega Hertz (MHz) network (trunking and conventional), it is designed for coverage within the City of Boston. The network may be used to ensure day-to-day communication in the event of a local or network telephone outage, provide command and control communication during emergency events, or request assistance and coordinate the response of additional medical resources.

## “BOSTON”- NETWORK CONTROL

“Boston” – Network Control provides for the coordination of communications over the Boston Health Center & Hospital Radio Network. The center is staffed 24 hours a day with specifically trained Boston EMS EMT-Telecommunicators. Listed below are a few of the functions of “Boston”:

- Coordinate Talk Group/Channel management with users and network resources.
- Monitor, as possible, radio traffic to determine the quantity and quality of transmissions, as well as conduct regular testing of the network, to detect and resolve outages.
- Provide general assistance as requested by any agency in accordance with system procedures.
- Provide Command/Control/Communications/Intelligence (C<sup>3</sup>I) functions during mass casualty or disaster responses in cooperation with authorized Incident Commanders.
- Serve as a regional clearinghouse for medical resource requests.

## TALK GROUP CHANNEL PLAN

Four dedicated Talk Groups, hereafter referred to as “Channels”, have been allocated for the Boston Health Center & Hospital Radio Network, along with channel use of other Boston “channels” in Zone A; Zone B contains public safety channels for emergency use – health centers and hospitals are not expected to use any of these “channels”. (See Zone/Channel matrix attached.) Additionally, a non-dedicated TALKAROUND, or “direct”, channel for non-network portable to portable transmission has been included in the event of a problem with the 800 MHz network. The following dedicated channels/names shall be used according to the principles of real-time sharing, make maximum use of the channels in a efficient manner, and ensure that the channels can be relied on for communications needs of the most critical nature. (See Zone/Channel matrix attached.)

**EMS 1:** Monitored at BEMS Dispatch Operations Division, used to contact “Boston” (network control).

**HEALTH CTR:** The **primary** channel radio users should monitor at all times, as notifications of incidents and/or information will be broadcast here. This also serves as the “common calling” channel: if one health center would like to communicate with another, they should call each other here, and then shift their conversation over to the adjacent Hospital 3 channel; lengthy, detailed, or time consuming communication should not occur on HEALTH CTR channel. Regular testing of the network will performed on this channel as well.

**HOSPITAL 3:** Assigned Inter-Health Center communication, it also serves as a back-up for Hospital Command (Hospital 1) and Logistics (Hospital 2) communication. Used for day-to-day, routine communication, users will shift to this channel after hailing each other on the primary channel; again, channel coordination will be conducted on the primary channel, HEALTH CTR.

**HOSPITAL 2:** Assigned Inter-Hospital Logistic communication, it also serves as back-up for Hospital Command (Hospital 1) and Inter-Health Center (Hospital 3). Used to coordinate

Logistic communication, users will shift to this channel after being hailed on the primary channel; again, channel coordination will be conducted on the primary channel, HEALTH CTR.

**HOSPITAL 1:** Assigned Inter-Hospital Command communication, it also serves as back-up for Hospital Logistics (Hospital 2) and Inter-Health Center (Hospital 3). Used to coordinate command and control communication, users will shift to this channel after being hailed on the primary channel; again, channel coordination will be conducted on the primary channel, HEALTH CTR.

**TALKAROUND:** Assigned for portable to portable communications, the transmissions do not go through the network and therefore have a very limited range. The channel is shared by all City users and all transmissions may be monitored.

**CITY EVENT:** Assigned for City special event coordination, health centers and hospitals would not normally monitor this channel unless specifically directed to do so.

**CITY EMERG:** Assigned to all radios in the system, this channel may be used to contact the Municipal Police Department in the event of an emergency (and may be monitored by Boston EMS Dispatch Operations).

Zone B contains public safety channels for emergency use – health centers and hospitals are not expected to use any of the channels.

## RULES OF USE

### **“Boston” Responsibility**

Radio communications which concern any of the Boston Health Center & Hospital Radio Network transmissions should be coordinated by the designated network control station, and “Boston” will receive and process all requests for group radio communications and/or support from any of the MBHSR agencies in the event of an emergency or large scale incident. Day-to-day use of the Boston Health Center & Hospital Radio Network is provided through the use of a common calling channel (HEALTH CTR) where different facilities can contact each other and shift to an appropriately designated channel for detailed communication.

During an emergency, communications between facilities shall be directed to “Boston” for coordination, unless open cross-talk has been authorized. “Boston” is responsible for monitoring and expediting radio traffic as possible to keep the network operating efficiently – transmissions should be as complete and brief as necessary. User issues identified by “Boston” shall be immediately addressed by the responsible facility; preservation of incident communications shall be prioritized over individual use.

### **Testing, Trouble Identification and Resolution**

Testing of the Boston Health Center & Hospital Radio Network will be performed regularly on the HEALTH CTR channel. Boston will send an alert tone, followed by scripted notification of the test and then an individual roll call of each facility. When called, facilities that hear Boston loud and clear shall respond with “Roger Test.” After calling a facility twice without answer, Boston will continue down the list until completed, and then retest with facilities that did not respond. Individual facilities experiencing radio trouble should advise Boston via radio or land

line (617-343-1400) as soon as possible so that they may be documented, assessed, and corrected.

Normal Boston Emergency Medical Services reporting and problem resolution procedures will be utilized. These include, but are not limited to: Loss of Coverage (in a known good area); Transmitter Failure; a stolen or other radio is being used or misused.

### **Disaster /Significant Event Procedures**

Definitive disaster procedures are the responsibility of regional and local agencies and individual facilities in conjunction with MMRS, BPHC and other City organizations. Users are expected to be thoroughly familiar with local procedures, the basic principles of the Incident Command System and those outlined in your own emergency plans (COOP and Pandemic Flu, Anthrax, Mass Dispensing, etc.). The Health Center and Hospital Radio Network is designed to support communication during emergency situations, both local and large scale, or when simultaneous communication with all health centers and hospitals improves the information relay or the coordination of joint decision making. While the channel plan has been designed flexible enough to meet the changing needs of an event, the following channel assignments have been designated to provide structure for the use of designated channels.

Command and control shall be conducted on HOSPITAL 1, while any Logistics traffic shall be on HOSPITAL 2, with health center cross talk communicated on HOSPITAL 3. (Again, cross-talk between Community Health Centers can be coordinated initially on HEALTH CTR, and if prolonged discussion is needed, both parties may shift to Hospital 3. Listen briefly before transmitting to ensure your transmission does not interfere with communication already on that channel.) Some examples of different types of communication, and the channels they might use, are explained below.

**Public Health Commission Emergency:** Command and control communication may be conducted on HOSPITAL 1 to discuss the Community Health Center role and responsibility in during an emergency. HOSPITAL 1 could also be used to give senior administrative staff ongoing situational updates and to be aware of shifts in the status of the health centers. A health center needing to close, due to a facility failure or resources being exhausted, would have significant impacts on the rest of the health network and would be another issue communicated on HOSPITAL 1.

**Protracted MCI:** In the event of a mass casualty incident, patients may self present at community health centers, overwhelming on site resources and requiring support by BPHC and EMS personnel. A community health center may request an immediate BEMS response to the site, and also to advise BPHC and BEMS command of its status. Issues related to site access, security and transportation may be conducted on the command and control channel: HOSPITAL 1, while immediate, individual requests for personnel, supplies or other support communication may be conducted on the Logistics channel: HOSPITAL 2.

**Mass Exposures and Prophylaxis:** In the event of a major exposure (e.g. Anthrax), medication will be deployed to pre-determined dispensing sites. BPHC will communicate information to the public about site locations via the media and also through Health Centers, which might be

communicated on the Command Channel: HOSPITAL 1. Review of Community Health Center operations, including impacts to internal staff and efforts to mitigate staff shortages, might be another example of Command, or Hospital 1 channel traffic. BPHC could also request the availability and redeployment of personnel, both clinical and support staff, to support dispensing sites, which might be communicated on the Logistic Channel: HOSPITAL 2.

In a Pandemic, patients presenting with flu like symptoms may be better directed to a Mass Care Shelter or Health Center. Here again, BPHC/MMRS might communicate information to the public about site locations via the media and also through Health Centers, which might be communicated on the Command Channel: HOSPITAL 1. Coordinated review of health center activity, including patient volume and type, or neighborhood health issues might also be communicated on HOSPITAL 1. Health Centers needing to refer patients into facilities for more definitive or extended care might coordinate the logistics of point of entry via HOSPITAL 2.

When the Boston Health Center & Hospital Radio Network is utilized during an emergency, prompt and repeated updates regarding the incident shall be communicated to and provided by “Boston” (or designated coordinator). Requests for assistance will be directed to the designated coordinator on a logistic channel. Hospitals that may receive patients, or nearby hospitals which may be indirectly impacted by an MCI, shall receive communication updates via normal procedure; a hospital might also use such information and determine if its institutional disaster plan should be executed. All information should be qualified according to the degree of information needed to be transmitted.

## **Mayor’s Emergency Alert Notification System (MEANS)**

### **MEANS PUBLIC NOTIFICATION ACTIVATION PROTOCOL**

#### **PURPOSE**

This document establishes a standardized activation protocol and acceptable use guidelines for the Mayor’s Emergency Alert Notification System (MEANS).

#### **APPLICABILITY**

This protocol applies to the City of Boston and its constituent agencies. MEANS procedures developed by City of Boston agencies must complement this protocol.

#### **SYSTEM CAPABILITY**

The MEANS is capable of quickly making a large volume of geographically-targeted telephone calls to deliver a recorded message. Under optimum conditions, the MEANS will make approximately 10,000 calls per hour based on a 30 second message. Residential telephone number data is updated monthly based on an extract of the 911 Master Street Addressing Guide (MSAG). Upon system activation, the public will have the ability to add their wireless phone number to the MEANS database via the City’s website ([www.cityofboston.gov](http://www.cityofboston.gov))

#### **GUIDING PRINCIPLES**

- The MEANS is intended for expeditious emergency notification of Boston’s residents and people working in Boston.

- When circumstances allow, City of Boston agencies will collaborate to determine whether or not the MEANS should be activated.
- When circumstances allow, City of Boston agencies will collaborate to craft the message to be delivered via the MEANS.
- The MEANS supplements existing methods of emergency public notification such as media releases and door-to-door notifications.
- The City will avoid overuse of the MEANS to ensure that the public does not become desensitized to the system's calls.
- Stakeholders like State and Federal agencies and public utilities will be made aware of the MEANS' capabilities in the event that they have critical information to share with the public in Boston.
- The public will be informed about what to expect from the MEANS through a coordinated media campaign.
- The City of Boston's On-site MEANS system will make approximately 10,000 calls per hour based on a 30 second message.
  - The City of Boston has access to an Off-site Callout Facility (OCF). In consideration of the quantity of recipients and the urgency of the message the Activating Authority must decide whether or not to use the Off-site Callout Facility.
  - Under optimum conditions, the off-site hosted callout facility will make 60,000 calls per hour based on a 30 second message.

## ACTIVATION

**Non-Immediate Activation (Appendix A):** When circumstances allow, the Mayor's Homeland Security Roundtable<sup>22</sup> (MHSRT) or a reachable subset thereof shall be convened in person or via conference call to consider activation of the MEANS. The MHSRT will consider MEANS activation based on the advance warning time of an impending event and the number of persons projected to be affected by the impending event. The MHSRT will designate the lead agency for public notification and that agency will have responsibility for MEANS activation.

**Immediate Activation (Appendix B):** If in the judgment of public safety and/or public health command personnel the risk to the public posed by a threat or hazard is immediate and the time necessary to convene the MHSRT via conference call (approximately 60 minutes) could endanger the public, the following Activating Authorities can approve immediate MEANS activation:

## ACTIVATING AUTHORITIES

Mayor's Office: *Contact via Mayor's 24-Hour Service 617-635-4500*

- Mayor
- Mayor's Chief of Staff
- Director, Mayor's Office of Homeland Security and Emergency Management

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<sup>22</sup> The **Mayor's Homeland Security Roundtable (MHSRT)** is comprised of the Mayor's Chief of Staff, the Mayor's Chief of Policy and Planning, Director of the Mayor's Office of Homeland Security and Emergency Management, Police Commissioner, Fire Commissioner, Boston Public Health Commission Executive Director, and Chief of Emergency Medical Services.

Boston Fire Department: *Contact via Fire Alarm 617 536-1500*

- Commissioner
- Chief of Department
- Chief of Operations
- On-Duty Deputy Chief
- Superintendent of Fire Alarm

Police Department: *Contact via Police Dispatch Center: 617 343-4680*

- Commissioner
- Superintendent-in-Chief
- Superintendent, Bureau of Field Services
- Night Superintendent
- Commander, Dispatch Center
- An Incident Commander with a rank of Sergeant or above, in consultation with the Dispatch Center Duty Supervisor

Boston Public Health Commission: *Contact via EMS Dispatch Center 617-343-1400*

- Executive Director
- Deputy Director
- Medical Director
- Director of Public Health Preparedness
- Director of Communicable Disease Control

Boston Emergency Medical Services: *Contact via EMS Dispatch Center 617-343-1400*

- Chief of Department
- Superintendent-in-Chief
- Superintendent
- On-Duty Shift Commander

#### DEACTIVATION AUTHORITY

Authority to cancel an active notification rests with the Activating Authority who initially approved MEANS activation OR that individual's relief if command was transferred in accordance with the principles of the Incident Command System and the National Incident Management System.

#### PUBLIC NOTIFICATION MESSAGING

##### IMPORTANT BACKGROUND INFORMATION:

- *The more recipients the longer your message will take to deliver.* As the quantity of recipients increases, callout speed decreases. Target MEANS messages to the smallest number of recipients to whom the message content is applicable.
- *Longer messages take longer to deliver.* As the length of the recorded message increases, callout speed decreases. Try to keep your recorded message less than 30 seconds.
- When the MEANS encounters an answering machine, the system will attempt to deliver the recorded message to the answering machine. In most cases, this will be successful.

- The recipient’s caller ID readout will read “City of Boston” unless the off-site callout facility is utilized in which case the ID will readout as an 800 number.
- The MEANS is set to timeout after five (5) rings.
- Non-Immediate Activation callouts shall be assigned second priority to ensure that Immediate Activation callouts have priority access to outgoing telephone lines.
- The MEANS will make three (3) attempts to contact each number unless the specified notification duration has expired.

MESSAGE CONTENT:

- Construct MEANS messages using the MEANS Message Form (Appendix C).
- Include one of the following messages in the introduction and closing of every notification as appropriate:
  - “This is an **emergency** message from the City of Boston...”
  - “This is an **informational** message from the City of Boston...”
  - “This is a **test** message from the City of Boston....”
- Deliver clear information about the risk posed by the emergency situation – stick to the facts.
- Describe action recipients must take to mitigate risk posed to them by the emergency.
- Provide a callback number or webpage where recipients can obtain more information.
- If appropriate, ask recipients to check on their elderly or homebound neighbors.

MESSAGE DELIVERY

- For informational messages, consider appropriate callout times. As a general rule, informational messages should be delivered between the hours of 8:00AM and 8:00PM.
- When recording:
  - Messages should be less than 30 seconds.
  - Compose messages in writing prior to recording.
  - Speak clearly, and calmly in a reassuring manner – “*inform, don’t frighten*”.
  - Use simple, plain language, avoid use of slang, acronyms or technical jargon (e.g. “HAZMAT”).
  - Include a date and time with each outgoing message.
  - Ensure clarity by testing the message prior to activating a public notification.

Avoid duplication of efforts and ensure situational awareness by copying all MEANS messages to the Mayor’s Office of Constituent Services (“24 Hour Service”), the Mayor’s Press Office, all MEANS user-agencies, public safety dispatch centers, the Massachusetts Port Authority Communications Center, and the Massachusetts Bay Transportation Authority Transit Police Communications Center and Massachusetts Turnpike Authority Operations Control Center.

**MEANS SYSTEM MANAGEMENT**

Overall management authority for the MEANS rests with the Director, MOHS-EM. MEANS system administration is undertaken by the City of Boston Management Information Systems. System access privileges must be approved by the MOHS-EM Director.

Persons authorized to operate the MEANS must participate in MEANS training prior to accessing the system. Users shall not disclose how to access or activate the system to anyone nor shall they activate the system in contravention to any protocols or procedures.

#### NON-EMERGENCY/TEST NOTIFICATIONS

Non-emergency notifications may be activated at the discretion of the Mayor, the Mayor's Chief of Staff, or the Director, Mayor's Office of Homeland Security and Emergency Management (MOHS-EM). Non-emergency notifications may decrease the level of attention the public gives to emergency notifications and must not be frequent. Test notifications to ensure system integrity shall be conducted on a monthly basis by the system administrator.

Use of the MEANS for profit, personal reasons, advertising of any product or service, or political messages is prohibited.

#### MAINTENANCE OF RECORDS

MEANS Message forms, operator logs, and system reports of calls made and responses received shall be forwarded within 7 days to the Director, Mayor's Office of Homeland Security and Emergency Management.

## PART G: Medical Control Plan

**105 CMR 170.510 (G):** Local jurisdiction(s) need to include a plan for medical control. At a minimum, this will consist of tracking current affiliation agreements, consistent with 105 CMR 170.300 for each ALS level EMS service providing primary ambulance response or EFR response (if any) operating in the service zone. If there are services operating in the service zone at the BLS level only, the service zone may want to track memoranda of agreement with hospitals for medication administration oversight as well.

### Medical Control Inventory

Provider	Affiliate Hospital	Medical Director	Contact
Boston EMS	Boston Medical Center	Dr. Sophia Dyer	617 343-2367

### Standard of Care

Boston EMS must first and foremost operate as a professional medical service. As such, members providing patient care services are held accountable to a standard of care in the same manner as are all other patient care providers.

The standard of care for Boston EMS has several components. The first component is the force of law standard. This is the standard imposed by Massachusetts General Law Chapter 111c, regulating ambulances and ambulance services and regulations hereinafter promulgated.

The next element is the standard of ethics by which an EMT or Paramedic is bound not to disclose details of patient history and/or treatment except as authorized to other professionals involved with patient care or as required by law.

The EMT and paramedic has a moral obligation to provide the best care possible to each patient he/she attends, as determined by the limits of his/her training, without regard for the patient's age, sex, religion, sexual orientation, or ability to pay.

Finally, Boston EMS has established institutional standards. These standards are described in the Statewide Treatment protocols issued by the Massachusetts Office of Emergency Medical Services, and by the Medical Director of Boston EMS.

## **Advanced Life Support Affiliation Agreement**

This Agreement is made and entered into between the Boston Public Health Commission acting through its Emergency Medical Services bureau (the Ambulance Service) and the Boston Medical Center (the Hospital).

- The Ambulance Service is licensed to provide pre-hospital Advanced Life Support (ALS-Paramedic) emergency medical services, and its emergency medical technicians (EMTs) are certified at the appropriate ALS level of care to allow the Ambulance Service to deliver ALS at the Paramedic level; and
- A key state regulatory requirement and clinical component of providing quality pre-hospital care at the Paramedic level is ensuring ALS personnel receive effective medical oversight services from a committed hospital with an emergency department staffed by physicians 24 hours per day, and
- The Hospital is equipped and committed to providing medical oversight services as described herein for the provision of pre-hospital ALS-Paramedic care by the EMTs certified to provide ALS care employed by the Ambulance Service; and
- The parties are committed to meeting the requirements of the Massachusetts Department of Public Health's (Department's) Emergency Medical Services Regulations, 105 CMR 170.300, regarding affiliation agreements between an ambulance service licensed to provide Advanced Life Support services and a hospital with an Emergency Department staffed by physicians 24 hours per day, in order to establish an effective plan for medical oversight.

The Ambulance Service Agrees:

1. To staff its ambulances assigned to provide ALS services with EMTs fully trained, oriented and certified at the appropriate ALS level.
2. To equip all ALS-Paramedic ambulances with the communication, treatment, and monitoring equipment required by the Department and the Hospital in order to provide effective EMS at the level of care for which the ambulance service is licensed.
3. To provide patient care in accordance with the Statewide Treatment Protocols.
4. To participate in the quality assurance/quality improvement (QA/QI) program operated under the direction of the Affiliate Hospital Medical Director, and in accordance with requirements of this Agreement.
5. To notify the Medical Director of all certified EMTs requiring authorization to practice.
6. To notify the Medical Director of all personnel changes involving certified EMTs who will provide pre-hospital ALS.
7. To provide the Medical Director with information regarding any certified EMTs who provide ALS care against whom there has been any disciplinary action taken by the Department, and/or for whom any remediation has been ordered or indicated.
8. To ensure that its certified EMTs are providing ALS care in accordance with the Medical Director's authorization to practice.
9. To provide the Medical Director with a copy of its current dispatch protocols.
10. To provide the Medical Director with a copy of all trip records, incident reports and, upon request, any other pertinent patient care related documents and data, related to the

Ambulance Service's provision of pre-hospital EMS in cases in which ALS was requested, even if not provided.

11. To ensure its certified EMTs providing ALS care participate in remediation, training and retraining, as necessary, under the oversight of the Medical Director, or his or her designee.
12. To follow Regional point-of-entry plan(s) approved by the Department and other relevant regulations, policies and administrative requirements of the Department.
13. To obtain those controlled substances indicated in the Statewide Treatment Protocols from the hospital and to adhere to the hospital's policies in regard to handling, dispensing, disposal and accounting of such substances.

The Hospital Agrees:

1. To provide medical control oversight to Boston Emergency Medical Services personnel.
2. To designate a medical director (Medical Director), who shall have authority over the clinical and patient care aspects of the Ambulance Service's provision of pre-hospital ALS services, including but not limited to the authorization to practice of its EMS personnel, and the denial or withdrawal of such authorization to practice.
3. To provide on-line medical direction in accordance with the Statewide Treatment Protocols 24 hours a day, seven days a week, by a hospital-based physician(s).
4. To comply with the State EMS Communication Plan regarding medical direction communications.
5. To operate, under the direction of the Medical Director, an effective quality assurance/quality improvement (QA/QI) program, in which on-line medical direction physician(s) shall participate.
6. To operate said QA/QI program in accordance with QA/QI standards and protocols.
7. To ensure that said QA/QI program shall include, but not be limited to, regular review of trip records and other data pertinent to the Ambulance Service's provision of patient care in cases in which ALS services were requested, whether ALS services were provided or not. Such review shall take place on an ongoing, regular basis through the ambulance service's Research, Training, and Quality Improvement Division.
8. In conjunction with the Boston Emergency Medical Service Research, Training, and Quality Improvement Division, operate a program for skill maintenance and review for each of the Ambulance Service's certified EMTs providing ALS care, in accordance with standards and protocols for effective skill maintenance and review.
9. To ensure each of the Ambulance Service's certified EMTs providing ALS care have access to remediation, training and retraining, as necessary, under the oversight of the Medical Director, or his or her designee. Such access to remediation, training and retraining shall at minimum include the provision of additional clinical and/or didactic training; skill maintenance in ER, OR, ICU, or simulation laboratory setting; participation in research projects; or other means as deemed necessary and appropriate by the Medical Director.
10. To provide regular consultation opportunities between its medical and nursing staffs and the Ambulance Service's certified EMTs providing ALS care, to review and discuss various aspects concerning the performance of the Ambulance Service's delivery of ALS care, including, but not limited to, attendance at morbidity and mortality rounds and chart

reviews, presentations during monthly training sessions, tabletop exercises, and ride-alongs observer programs.

Both Parties Agree:

1. To implement and maintain a program for skill maintenance and review of the Ambulance Service's certified EMTs providing ALS care, in accordance with standards and protocols for effective skill maintenance and review.
2. To implement and maintain a procedure by which a Hospital physician can maintain recorded direct verbal contact with the EMT regarding a particular patient's condition and order, when appropriate, the administration of a medication or treatment for that patient.
3. To be responsive to the other party's concerns and needs, acting in a timely manner to resolve all problems and meet reasonable needs.
4. To review this document at least annually, and make any updates necessary to ensure it is consistent with current practice.
5. To notify the Department of Public Health's Office of Emergency Medical Services in writing should any changes occur altering the specifics of the agreement.

### **Accredited Training Institution**

The Boston EMS Research, Training, and Quality Improvement (RTQI) Division, having met the following requirements, has been designated as an accredited training institution at the basic, intermediate, and paramedic level by the Massachusetts Office of Emergency Medical Services.

#### 170.946: Accreditation of Training Institutions: General Provisions

(A) **Eligibility.** A training institution seeking Department accreditation shall be an organization capable of providing programmatic and fiscal oversight of, and assuming accountability for, the instruction, operation, performance and evaluation of the training of EMTs and EMT-candidates. To be eligible to apply for accreditation, the training institution must provide, either directly or through contractual arrangements with a Department-accredited training institution or post-secondary educational institution, a basic infrastructure that:

1. Employs quality assurance/quality improvement procedures for assessing the institution's performance;
2. Adequately assesses the performance of instructors and assumes clear accountability for its instructors;
3. Adequately assesses the performance of its students;
4. Provides its students with adequate access to research and learning tools and materials, including, but not limited to, library facilities, computers, audio-visual educational aids and other technology determined to be necessary by the Department;
5. Provides adequate classroom facilities and practical skills training areas; and
6. Provides adequate administrative support.

## PART H: Operational Plan for EMS Response

**105 CMR 170.510 (H):** Please explain your operational plan for coordinating the use of all EMS resources

- Primary ambulance service
- Designated EMS first response (EFR) services, if any
- First responder agencies Ambulance services with private provider contracts
- Primary ALS service, if any -- in the service zone

This can be done by diagram or text or both.

The operational plan must:

- a) Explain how all EMS resources are to be used, and
- b) How the service zone shall ensure the response of the closest appropriate available EMS resources.

Pursuant to 170.510, the Operational Plan may not include criteria for notification and dispatch of a designated EFR service to health care facilities licensed by the Department:

- a) Where there is a licensed health care professional 24 hours per day, seven days per week,
- b) AND where there is a provider contract in place to provide primary ambulance response.

### **Boston EMS Organization and Administration**

Boston EMS is structured into a series of organizational components that represent functional groupings of employees performing similar activities. This structure provides management with a means of assigning responsibility for performance of a group of functions to a single supervisor or manager, and clarifies to whom specific employees are accountable.

The structure of the organization is management's mechanism for bringing together and coordinating resources to accomplish goals and objectives. The Chief of Department may establish any organizational units and assign functions as deemed necessary to support the effective and efficient accomplishment of the agency's goals, objectives, responsibilities, and functions. The Department will establish a table of organization, which will be periodically updated to reflect changes and will be made available to all department personnel.

## **BEMS System Overview**

Boston EMS is the lead agency for the provision of emergency medical services for the City of Boston. The Boston emergency medical services system is comprised of public and private organizations that provide a comprehensive delivery of pre-hospital and in-hospital emergency medical care. Boston EMS is responsible for the management of the pre-hospital component: first responders, Basic Life Support, Advanced Life Support, and telecommunications. Private and municipal ambulance services provide back-up support through mutual aid agreements as needed. The Conference of Boston Teaching Hospitals is a consortium of local hospitals and their EMS departments. Boston EMS and the Conference of Boston Teaching Hospitals are continually evaluating and improving the delivery of emergency care especially in the area of multiple casualty preparedness.

1. ***Coordination of Scene Care*** - Working closely with other public and private agencies, EMS personnel shall direct and coordinate the provision of emergency medical care on scene and en route to a hospital.
2. ***Pre-Hospital Communications*** - Communication between units and/or with a hospital emergency department is accomplished by a multi-channel ultra-high frequency (UHF) radio coordinated by the Boston EMS Dispatch Operations Center.
3. ***Basic Life Support Ambulances*** - Basic Life Support ambulances are deployed in districts throughout the City, and respond to all types of medical emergencies. District ambulances are staffed by Boston EMS certified EMTs who administer Basic Life Support skills. EMTs are also trained in telecommunications, emergency vehicle operation, infection control, multiple casualty incident management, hazardous material and mass casualty incident (MCI) management.
4. ***Advanced Life Support Ambulances*** - Advanced Life Support ambulances are deployed in zones, and respond primarily to emergencies considered life-threatening or urgent. Boston EMS certified Paramedics who staff the ALS units are certified to administer intravenous, subcutaneous, and endotracheal medication; to interpret cardiac arrhythmias, defibrillate, and perform synchronized cardioversion; to perform endotracheal intubation; and to perform other Advanced Life Support techniques as required.

## **BEMS Organizational Structure**

The following description is not intended to be all inclusive, but rather give an overview of the organizational structure of the Department. The executive head of the department is the Chief of Department. He/she is responsible for supervising the Office of the Chief as described below and managing all of the organizational components and functions of the Department through his/her Command Staff.

- Office of the Chief
- Operations
- Administration and Finance
- Research, Training, and Quality Improvement
- DeValle Institute for Emergency Preparedness

### *OFFICE OF THE CHIEF*

The Chief of Department, in close consultation with the Medical Director is responsible for the management, planning, direction and control of the Department. The Chief of Department reports to the Boston Public Health Commission Board of Directors through the Executive Director of the Public Health Commission.

### *OPERATIONS*

Reporting directly to the Chief of Department, the Superintendent in Chief oversees all aspects of the delivery of quality, efficient pre-hospital care. Operations is responsible for the staffing, call processing, response, deployment, and conduct of all response units; for patient care; the disposition of requests for ambulances for details and special events; the enforcement of all operational and clinical protocols, community outreach and employee recruitment.

**Field Operations Division:** Under the direction and oversight of a Superintendent, Field Operations is comprised of all field response units, including Shift Commanders, Field Supervisors, and both Basic and Advanced Life Support ambulances. Field Operations comprises the largest and most visible area of the department.

**Emergency Preparedness / Special Operations:** Under the direction and oversight of a Superintendent, Emergency Preparedness is responsible for both tactical and operational planning for major events and homeland security issues throughout the City.

- Special Operations Division: Provides planning, logistics and consequence management for major events, both planned and unplanned, throughout the City including special events, VIP protection, hazardous materials and mass casualty incident support.
- Homeland Security: Office of Homeland Security works closely with other homeland security offices established within the City and throughout the metropolitan area. It focuses on long-term all hazard planning and grant administration while working with City, State, and federal partners.
  - MMRS Coordinator
  - UASI Coordinator
  - Mayor's Office of Homeland Security Liaison

**Field Support:** Under the direction and oversight of a Superintendent, Field Support is comprised of Support Services Division; Professional Standards Division; Policy and Planning; and Data Analysis. .

### *ADMINISTRATION AND FINANCE*

The Director of Administration and Finance is responsible for budget preparation and management, PCR processing for ambulance transport billing, procurements and contract management, oversight of hiring, clerical support, workers' compensation processing, and the maintenance and integrity of office business equipment. Administration and Finance is comprised of the following areas:

Budget Office is responsible for collecting timekeeping data and managing the Department's payroll. The Budget office also prepares the Department's annual budget submissions, establishes budget-related policies, monitors contracts, and grant administration. The Budget

office develops and monitors spending control plans, processes accounts payable and accounts receivable; and performs associated financial analysis.

Management Information Systems Section: The Management Information Systems Section is responsible for establishing and maintaining systems and software for business information, computer operations, and network facilities. Information Systems personnel develop policies and procedures to maintain data security throughout both the intranet and extranet network configuration.

Materials and Facilities Management Section is responsible for coordinating facility maintenance repair requests and renovations, manages and accounts for the supplies and equipment necessary for the ongoing needs of the department including durable and disposable equipment, uniforms and pharmaceuticals. Materials and Facility Management staff retrieve and decontaminate equipment from area hospitals, and provide on scene support during large scale incidents.

#### *RESEARCH, TRAINING AND QUALITY IMPROVEMENT (RTQI)*

RTQI is accredited by the Massachusetts Office of Emergency Medical Services (OEMS) as a Training Institution for EMT Training at the Basic, Intermediate, and Paramedic Level. Under the direction of the Medical Director, RTQI is responsible for maintaining and reviewing the certification of all personnel; for scheduling and coordinating Continuing Education, refresher and CPR courses as required; for establishing and monitoring the competence of new employees through the BEMS recruit academy; for conducting clinical review sessions; and for developing public education and clinical research programs.

RTQI oversees the Department's EMS Fellows program, community semi-automatic external defibrillator (SAED) outreach, reviews patient care reports (PCR), controlled substance administration records, cardiac arrest data and other available clinical information as part of a comprehensive quality assurance and quality improvement program. The Department's designated infection control officer (DICO) is responsible for all aspects of the Infection Control procedure and facilitates exposure follow-up and immunizations as necessary.

The Community Initiatives unit within RTQI is responsible for coordinating community outreach and marketing efforts, including targeted programs such as injury prevention, community education, and employee recruitment.

#### *DELVALLE INSTITUTE FOR EMERGENCY PREPAREDNESS*

The DelValle Institute for Emergency Preparedness provides high quality, all-hazards training for the Boston community, including public health, health care and public safety personnel, with a focus on chemical, biological, radiological, nuclear and explosive incident preparedness, response and recovery.

### **Chain of Command**

There are two functional chains of command: operational and clinical. The operational chain of command describes the levels of responsibility and authority concerning administrative and procedural matters (e.g., the adherence to rules and regulations contained in this manual). The clinical chain of command describes the levels of responsibility and authority according to the degree of clinical training and certification (e.g., Basic Life Support and Advanced Life Support).

### Operational Chain of Command

The following are named by title and are listed according to authority and responsibility in descending order:

- Chief of Department
- Superintendent in Chief
- Superintendent
- Deputy Superintendent
- Captain
- Lieutenant
- BEMS EMT-Paramedic
- BEMS EMT-Defibrillation
- BEMS Recruit

### Clinical Chain of Command

The following are named by title and are listed according to authority and responsibility in descending order:

- Medical Director
- Associate Medical Director
- BEMS EMT-Paramedic
- BEMS EMT-Defibrillation
- BEMS Recruit

### **Unity of Command**

Each member is accountable to only one supervisor at any given time. Each member shall be responsible or accountable to his regular immediate supervisor, except when working on a special assignment, incident, or temporarily assigned to another unit. In such cases, the member shall be accountable to the supervisor in charge of the assignment or incident. Similarly, each organizational component shall be under the direct command of only one supervisor as shown on the Department organizational chart. At times, a commanding officer may be required to give a lawful order to a member or component that is outside of his normal chain of command. In such cases, rank will be respected and the order shall be obeyed. Employees will be given commensurate authority to accomplish their responsibilities. Each employee will be held accountable for the use of delegated authority. Supervisory personnel are accountable for the activities of employees under their immediate supervision and control.

### **Command of Joint Operations**

When two or more components within the Department are engaged in a joint operation, the person in charge shall be clearly identified to all participants at the beginning of the operation.

## **Succession of Command**

In order to ensure continuity of command, section Commanders or managers have the authority to designate a temporary replacement for short-term absences due to vacation, training, etc subject to approval of the Chief of Department. In the absence of the Chief, the Superintendent in Chief will act for the Chief and with his authority. The succession of Command will continue through the chain of command based on position and seniority, unless otherwise directed by competent authority. An Acting Chief is authorized to carry out all powers, authority, and duties conferred upon the Chief, except promoting or demoting a member of the Department without the authorization of the Chief or Executive Director of the Public Health Commission.

## **Concepts of Integrated Emergency Management**

1. Mitigation
  - a. Preventative Health & Safety programs.
  - b. Private sector Semi-Automatic External Defibrillator (*SAED*) introduction.
  - c. Corporate linkage for disaster planning.
2. Preparedness
  - a. Research and develop resource lists for services that may need to be provided during an emergency.
  - b. Develop and implement plans, training and exercises at regular intervals, to insure system competence in mass casualty response.
  - c. Develop and maintain mutual aid agreements or memorandums of understanding.
  - d. Maintain adequate medical supplies for emergency use.
3. Response
  - a. Activate Incident Command System (*ICS*) and assume medical command of the incident.
  - b. Patient triage and tagging.
  - c. Patient decontamination assurance.
  - d. Patient stabilization by definitive medical care.
  - e. Medical communications and coordination.
  - f. Patient transportation and sheltering.
  - g. Patient record keeping.
  - h. Medical intelligence and patient information interpretation.
  - i. Public health system surveillance and integration.
4. Recovery
  - a. Coordination of specialized health & emergency medical services.
  - b. Compilation of health reports for city, state, and federal agencies.

## **BOSTON CMED**

1. Coordinates all medical communications.
2. Determines hospital critical care bed status and maintains hospital disaster level patient capacity.
3. Activates area hospital notification radio network on VHF frequency 155.280 MHz.
4. Secure appropriate medical destination for all patients.
5. Orders hospital destination upon request of Loading Officer.
6. Maintains records of number and destination of transported patients.
7. Coordinates on-line physician direction for on-scene EMS personnel.
8. Determines, as needed, availability of critical care space in hospitals in neighboring communities.
9. Coordinates ambulances, including air and maritime ambulances, for redistribution of patients to / from Boston hospitals.

## **BOSTON MEDICAL CENTER**

1. Provides on-line physician control for on-scene EMS personnel.
2. Activates internal Emergency Plan commensurate to the incident phase.
3. Disaster Chief, Boston Medical Center
  - a. Supervises all aspects of hospital based medical treatment during disaster.
  - b. Implements internal disaster plan.

### **Direction and Control**

The Chief of Department of Boston EMS, in close consultation with the Medical Director holds statutory responsibility for all aspects of emergency medical response in the City of Boston. Consequently, any department, unit, agency or company that provides EMS personnel or EMS support to the City of Boston falls under the control of the Boston EMS Incident Commander or his/her designee.

### **Administration and Logistics**

#### **A. Boston Medical Center**

Boston Medical Center will serve as the Medical Command Center for the City's medical response during an emergency situation. The Disaster Chief, staff, and support staff will coordinate the medical response with EMS and all other hospitals. Continuous communications should be maintained with the Boston EMS Dispatch Operations Center and the City of Boston Emergency Operations Center (EOC).

#### **B. Bed Status Report**

Boston EMS will determine the number of hospital beds available for emergency use. Bed Status reports will specify the number of intensive care and general hospital beds available immediately, and additional beds that could be available after feasible discharges, transfers to nursing homes and to hospital holding areas. Bed Status reports should be updated regularly and forwarded through Boston CMED.

C. **Public Information**

The Boston EMS Public Information Office is responsible for providing information concerning health and medical operations, concerns or alerts to all media outlets and the public in general.

D. **Non-Discrimination**

Discrimination on any grounds including, race, color, religion, nationality, sex, age, or economic status in the execution of Emergency Medical Services will not be tolerated.

### **Primary Ambulance Response**

No ambulance service shall provide primary ambulance response within the City of Boston unless it is acting pursuant to a service zone agreement or agreement to provide back-up services. When an ambulance service other than Boston EMS receives a call to provide primary ambulance response within the City of Boston that is not pursuant to a provider contract and a service zone agreement, it must immediately refer the call to Boston EMS. *(170.355.B.1 + 4)*

When an ambulance service with a provider contract providing primary ambulance response pursuant to a service zone agreement receives a call for primary ambulance response, if it believes at the time the call is received that it cannot meet the service zone standards for primary ambulance response, the ambulance service must immediately refer the call to Boston EMS, unless otherwise provided in this service zone or service zone agreement. *(170.355 B.3)*

### **Provider Contracts to Respond to Emergencies**

All services shall provide written notification to Boston EMS of all provider contracts they have for primary ambulance response within the City of Boston service zone. Services shall provide notice to Boston EMS, at a minimum, when an initial provider contract is established, a provider contract is terminated or renewed, or any changes are made to the provisions of a provider contract relating to emergency calls. For contracts to provide coverage at special events, including multi-jurisdictional special events, at venues with which the service does not have a prior existing provider contract for primary ambulance response on a regular basis, advance written notice shall be provided to all jurisdictions implicated by the events. Such notification may be made to: [ServiceZone@BostonEMS.org](mailto:ServiceZone@BostonEMS.org) or by contacting the individual(s) listed in Part A as being responsible for monitoring compliance with the service zone plan. Boston EMS shall execute a service zone agreement with each ambulance service that notifies it, in accordance with 105 CMR 170.248, that the ambulance service has a provider contract for primary ambulance response in the City of Boston. *(170.248)*

### **Long Term Care Facilities Requesting EMS**

105 CMR 150.002 (H) requires that the administrator shall develop and implement policies and procedures governing emergency transport. Such policies and procedures shall include criteria for deciding whether to call the emergency telephone access number 9-1-1 or its local equivalent, or a contracted private ambulance service provider, if any, in response to an emergency medical condition. The criteria for determining whether to call 9-1-1 versus the contracted provider shall

address such factors as the nature of the emergency medical condition, and the time to scene arrival specified in relevant agreements with the contracted provider, if any.<sup>23</sup>

### **Incident Dispatch / Notification of First Responder(s)**

Boston EMS deploys its field units from EMS satellite stations strategically deployed across the City. Each field unit has a defined primary response area. When a call is received at the PSAP, the CAD system recommends the closest available BEMS field unit. EMS Dispatchers can also check the location of a Boston EMS unit by using an AVL system. If the field unit for a given primary response area is not available, the closest available ambulance is then recommended for dispatch. In addition, Boston EMS deploys zone impact units. These are additional ambulances deployed throughout the City and overlap the primary response areas. These zone impact units may be redeployed by the dispatcher, operations supervisor, or deputy superintendent according to need. Boston EMS also utilizes dynamic deployment at times of high call volume or low unit availability. By proactively “reposting” an ambulance to a section of the City in which other EMS resources are otherwise committed, EMS units will be in position to respond to anticipated calls for service.

During particularly high system demand, either because of an increase in calls for service (demand) or limited availability (supply), the Department can implement a number of strategies. For example, if the increased demand is due to a heat wave or other foreseeable event, Boston EMS will frequently anticipate this demand by increasing staffing. Additional units may be placed in service for the entire shift, bike or other Special Operations resources may be placed in service, or back-up services may be contacted for assistance. Call load can also be managed by referring low priority incidents to mutual aid services, or dispatching single person units (supervisor, squad or bike unit) or first responders to determine the need for an EMS response, thus keeping primary ambulances available for emergencies.

### **Patient Assessment and Transport**

The minimum equipment to be carried upon initial approach to a patient will often depend on a variety of factors, including the location of the patient (on the street, in a home, at a construction site), the number of EMS personnel arriving (single Supervisor vs. two person BLS or ALS crew), level of certification of the EMS personnel involved (e.g.: Basic Life Support vs. Advanced Life Support), the number of patients (single patient vs. multiple casualty incident), the age of the patient, and the reported nature of the emergency (medical call vs. trauma).

In general, the minimum equipment to be carried by BLS personnel upon the initial approach to a patient will be a jump kit/first aid kit, portable resuscitator, and semi-automatic defibrillator. A stair-chair, wheel-cot, or other appropriate means of transporting the patient to the ambulance shall also be brought to the patient’s side upon initial approach. Minimum equipment to be carried by ALS personnel upon the initial approach to a patient will be a jump kit, portable resuscitator, monitor / defibrillator, and medication box. When the ALS crew is sent “solo” or there will be a

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<sup>23</sup> Department of Public Health, DHCQ Circular Letter 05-10-451. “Revised Guidelines for Long Term Care Facility Emergency Ambulance Transport Guidelines”. Available online at: [http://www.mass.gov/dph/dhcq/cicletter/cir\\_letter\\_05\\_10\\_451.pdf](http://www.mass.gov/dph/dhcq/cicletter/cir_letter_05_10_451.pdf)

significant delay until the arrival of the BLS crew, the ALS crew should also bring a transport device upon initial patient approach.

#### SHARED RESPONSIBILITY FOR PATIENT CARE

When EMS was in its infancy, the “ambulance driver” and “attendant” had very defined roles. Because the “ambulance driver” had no medical training, all patient care activities were the responsibility of the “attendant”. Nowadays, both crewmembers are highly trained medical professionals and essentially act as team at the scene of an emergency. As such, all members on scene have a duty to ensure that the patient is receiving adequate and appropriate treatment. Disagreement over the scope of patient care shall be settled with a conservative approach. For example, if there is a question as to whether a splint should be applied or not, the splint shall be applied; if there is any question as to whether oxygen should be administered, or a long backboard should be applied, the more aggressive course of treatment shall be pursued.

#### PATIENTS TO BE TRANSPORTED ON WHEELCOT

Once in the ambulance, all patients “shall be properly secured to the ambulance cot, using all of the required straps, or in an approved infant/child carrier or seat, or harness, or in an appropriate immobilization device, in a position of comfort, or in a position appropriate to the chief complaint and/or the nature of the illness or injury. The federal GSA specifications for ambulance equipment (KKK 1822) require that the patient be secured to the cot to prevent **horizontal, latitudinal and rotational** movement. A court ruling under the federal “common carrier” statute stated that an ambulance service, “...must therefore equip its vehicles with the equipment which would provide the greatest degree of protection...” The state ambulance equipment list requires all stretchers to be equipped with an over the shoulder harness, hip and leg restraining straps. Proper securing of a patient means the use of all required straps, at all times. If patient care requires that a strap be removed, the strap must be re-secured as soon as practical”.<sup>24</sup> If a patient refuses to be transported on the wheeled cot and instead insists on sitting on the squad bench, this shall be noted on the PCR. When transporting more than one patient, additional patients may be transported on the bench seat. Patients who are ambulatory may be assisted to a wheelchair upon arrival at the hospital for transport into the emergency room.

### **EMS Incidents at Logan International Airport**

The MassPort Fire Rescue Department provides first responder services for Boston EMS incidents at MassPort property and facilities located at Logan International Airport.

1. Upon notification of a medical emergency occurring on MassPort -Logan International Airport property, the EMT Telecommunicator shall modify the combined incident mask to delete the Boston Fire Department and Boston Police Department from any combined incident prior to CAD entry.
  - 1.1. Calls received directly from MassPort Fire Alarm or Massachusetts State Police assigned to Logan International Airport shall be assumed to be on MassPort property unless otherwise noted by the caller.

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<sup>24</sup> Commonwealth of Massachusetts Pre-Hospital Treatment Protocols, 6<sup>th</sup> Edition, pp 15-16.  
[http://mass.gov/dph/oems/protocol/treatment\\_protocols.pdf](http://mass.gov/dph/oems/protocol/treatment_protocols.pdf)

- 1.2. Any call received via the E 9-1-1 system in which the ALI monitor shows the Emergency Service Zone to be MassPort Fire Rescue and Massachusetts State Police (ESN 479) shall be modified to delete the Boston Fire Department and Boston Police Department from the combined incident prior to CAD entry.
2. The MassPort Fire Alarm shall be notified of all medical emergencies occurring on MassPort-Logan International Airport property reported to Boston EMS by any person or agency other than the MassPort Fire Alarm or Massachusetts State Police.
  - 2.1. The EMT Telecommunicator entering the call is responsible for notifying the MassPort Fire Alarm of the nature and location of the emergency.
3. It shall be the responsibility of MassPort Fire Alarm personnel to notify other MassPort units and airport agencies (MassPort Fire Rescue, State Police, US Customs, Airline Security, etc.) of the incident.
4. MassPort Fire Alarm is responsible for notifying the Boston Fire Department of any mutual aid requests.

### **Marine Rescue**

Boston EMS works cooperatively and trains with the United States Coast Guard, Massachusetts State Police-Marine Division, the Boston Fire Department, the Boston Police Harbormaster, and other agencies that operate on the waterways in and around Boston to ensure plans are in place to respond to maritime emergencies. During summer months or planned special events, Boston EMS personnel are assigned to the Boston Police Harbor Unit as part of normal staffing. When a maritime emergency occurs and the BPD Harbor Unit is not staffed by a Department EMT, procedures are in place whereby an EMT crew is picked up by a Boston Fire Department boat to respond to the incident. Helicopters have also been used in the past to respond to incidents on one of the harbor islands.

### **Mass Casualty Incidents**

The mass casualty mission and approach is different from the day-to-day EMS routine. In a mass casualty situation, EMS responders should treat the whole group of victims as one, keeping in mind that the objective is to achieve the greatest good for the greatest number of victims. Therefore, treatment protocols intended for treating a single patient may be modified with dealing with multiple patients. For example, patients who normally might receive advanced treatment may be transported BLS to expedite transport and maximize resources. The goal of an MCI plan is to ensure rapid medical assistance is received by victims and to provide this assistance through adequate and coordinated efforts that will minimize loss of life, disabling injuries, and human suffering.<sup>25</sup>

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<sup>25</sup> Commonwealth of Massachusetts Statewide MCI Standards for Local Planning. Available at: [http://www.mass.gov/dph/oems/ambulance/ems\\_mci\\_planning\\_guide.pdf](http://www.mass.gov/dph/oems/ambulance/ems_mci_planning_guide.pdf)

## PART J: Delivery of Trip Records / Unprotected Exposures

**105 CMR 170.510 (J):** Explain the procedures the service zone will require to coordinate getting required EMS call documentation – Trip records and, when applicable, unprotected exposure forms – to receiving health care facilities.

Under **105 CMR 170.345(C)** of the EMS regulations, EMTs who transport the patient to the hospital deliver the trip record and any unprotected exposure forms directly to the hospital with the patient or as soon as practicable thereafter.

However, those EMS personnel who are at the scene but do not transport the patients still need to prepare trip records and, when the circumstances apply, unprotected exposure form(s), and get these to the hospital timely.

How they do that – how submission of all EMS responders' paperwork to the receiving hospital gets coordinated – is in accordance with procedures set out in the service zone plan.

### Patient Care Reports

All first responders and licensed ambulance services operating within the City of Boston service zone shall have written policies in place regarding patient care reports. Boston EMS supervisors will provide guidance and, to the extent possible, assistance in filling out required documentation, but personnel from the affected agency itself will be ultimately responsible for ensuring delivery of said reports to the appropriate medical facility in accordance with all applicable local, state, or federal regulations.

In accordance with 105 CMR 170.345 (B) Boston EMS maintains Computer Aided Dispatch records on all requests for emergency medical service. Department standard operating procedure also require personnel to complete a patient care report (PCR) on all cases, unless the unit was cancelled by dispatch prior to arrival on scene, in which case the incident will be documented via the Computer Aided Dispatch (CAD) record.

Boston EMS uses an electronic patient care reporting and information management system. The system allows users to collect and document call and patient information on mobile computers throughout the course of the EMS call. PCRs are prepared contemporaneously with, or as soon as practicable, after each response, and are then available for review by the hospital staff immediately after upload to the server. The system is HIPAA compliant and allows hospital personnel to review reports on patients transported only to their facility, while providing EMS managers and physicians will valuable QA, statistical, billing, and demographic information. The system allows managers to identify trends in patient condition based on quantitative statistics within a geographic region, thus serving as a potential early warning system for potential biological incidents, a spike in narcotic overdoses, or other criteria.

## Unprotected Exposure Reports / Infection Control

All EMS First Responder, First Responder, and licensed ambulance services operating within the City of Boston service zone shall have written infection control policies in place. Boston EMS supervisors will provide guidance and, to the extent possible, assistance in filling out required forms in the case of an exposure, but personnel from the affected agency itself will be ultimately responsible for ensuring delivery of said reports to the appropriate medical facility in accordance with all applicable local, state, or federal regulations. Boston EMS' infection control policy is follows:

### GENERAL STATEMENT

This policy sets forth infection control practices and procedures for all Department members. The purpose is to decrease the risk of contamination and infection for patients, Department members, and the general public. The Department encourages input from employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls. All unprotected exposures shall be documented and thoroughly investigated to ensure compliance with existing procedures. This policy shall be reviewed annually and updated as necessary to reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens.

**DEFINITIONS** For the purposes of this policy and procedure, the following shall apply:

**Blood** means human blood, human blood components, and products made from human blood.

**Bloodborne Pathogens** means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

**Contaminated** means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

**Contaminated Laundry** means laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

**Contaminated Sharps** means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

**Decontamination** means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

**Designated Infection Control Officer (DICO)** means the officer appointed by each ambulance service, EMS first response (EFR) service, as defined in 105 CMR 170.020, and first responder agency, as defined in 105 CMR 171.050, for the purposes of, but need not be limited to, (1) receiving notifications of exposures to infectious diseases dangerous to the public health from health care facilities and (2) notifying the indicated care provider(s) of an exposure to an infectious disease dangerous to the public health.

**Engineering Controls** means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.

**Exposure Incident** means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

**HBV** means hepatitis B virus.

**HCV** means hepatitis C virus.

**HIV** means human immunodeficiency virus.

**Needleless systems** means a device that does not use needles for:

(1) The collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; (2) The administration of medication or fluids; or (3) Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps.

**Other Potentially Infectious Materials** means (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

**Parenteral** means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

**Personal Protective Equipment** is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

**Sharps** are discarded medical articles that may cause puncture or cuts, including but not limited to used and discarded hypodermic needles; syringes; broken medical glassware; scalpel blades; disposable razors; venipuncture equipment.

**Source Individual** means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee.

**Sterilize** means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

**Universal Precautions** is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

**Work Practice Controls** means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

## ASEPTIC PROCEDURE

Aseptic procedures shall be used to prevent cross contamination. This includes wearing appropriate protective barriers to contamination such as gloves and masks, and avoiding touching the hair, glasses, clothing or any other "unclean" surface or object immediately before or during treatment of the patient.

## PRECAUTIONS

A Department member who has either been exposed to, or exhibits the signs or symptoms of, or has been diagnosed with the following illnesses shall notify the Shift Commander or in his/her absence the manager-on-call: measles; chicken pox; pertussis; rubella (German Measles); tuberculosis; meningococcal disease, unexplained and prolonged diarrhea; draining lesions; smallpox, monkeypox, or plague. The Shift Commander or the manager-on-call shall have the Designated Infection Control Officer (DICO) notified of the exposure by the EMS paging system. The Designated Infection Control Officer or the Occupational Health Program will determine if it is necessary for the Department member to remain off-duty because of a potential infectious disease.

## IMMUNIZATIONS

1. The Department strongly recommends that all members receive the hepatitis B vaccine and yearly tuberculosis (TB) testing. Annual PPD testing will be performed on all members who have patient contact, unless the member has a documented prior positive PPD with a subsequent chest radiograph and clinical evaluation for treatment.
2. Members must be knowledgeable of their history of vaccinations and the current status of vaccinations for hepatitis B, tetanus, diphtheria, measles, mumps and rubella (MMR). Members must also know whether or not they have had chickenpox (varicella) or the varicella vaccine with written documentation.
3. Members must have on file with the Occupational Health Program documentation of immunity to measles, mumps, rubella, tetanus, diphtheria, chickenpox, and hepatitis B. Acceptable documentation shall be written records containing the appropriate vaccination dates (including month and year) or serologic test results.
4. Members who test positive for tuberculosis after a PPD (purified protein derivative) skin test must have on file at Occupational Health documentation of the positive test and of a subsequent chest radiograph and evaluation for treatment. Repeat Chest radiographs are indicated only if an individual develops signs or symptoms suggestive of TB. If any member, particularly a member with a history of positive PPD experiences any of the following signs and symptoms, the member must be evaluated at Occupational Health or provide documentation of an acceptable evaluation from a personal physician: cough greater than two weeks, particularly if the cough is productive or there is hemoptysis; unintentional weight loss greater than ten (10) pounds; loss of appetite; easily fatigued without apparent reason; night sweats or fever for more than two (2) weeks.

## STERILE SUPPLIES

1. All sterile supplies and sterile solutions shall be kept sealed and in a clean dry area until used. Once sterility has been compromised, supplies shall be discarded immediately and replaced.
2. All solutions and sterile supplies on the ambulance shall be checked for expiration dates and for package integrity by the assigned members during the daily equipment check. Expired or contaminated solutions or supplies shall be returned to Materials/Facility Management.

## HANDWASHING REQUIRED

Handwashing is required at the start of the shift, after using toilet facilities, after each patient contact, and after vehicle or equipment cleaning or maintenance. An alcohol-based solution for hand sanitizing is available on each ambulance and shall be used after patient contact or contact

with blood/body fluids when running water and soap are not available. The handwashing procedure shall be repeated with soap and running water as soon as possible.

## LAUNDRY

1. Linen (sheets, towels, pillowcases and blankets) that is stored on-board vehicles for patient use shall be placed inside a clear plastic bag. Sheets, towels, or pillowcases shall be changed between each patient use. Sheets, towels, or pillowcases that have been used or soiled shall be disposed of in the appropriated laundry receptacle at the receiving emergency department.
2. Used or soiled sheets, towels, or pillow cases shall not be disposed of at the Material/Facility Management, the main ambulance, District Station, or other EMS facility.
3. Woolen blankets shall not be disposed of at the receiving facility. Soiled woolen blankets shall be placed inside a blue plastic soiled linen bag, and stored in the exterior compartment of the ambulance until they are exchanged or replaced at Material/Facility Management. In the event that Material/Facility Management is closed, and there is an excess of soiled woolen blankets stored in the exterior compartment, the excess blankets shall be deposited in the designated laundry hamper at the District Station.

## PATIENTS

1. All Blood and Body Fluids shall be considered potentially infectious.
2. All members must wear gloves whenever they are involved in patient care that may expose them to blood or bodily fluids.
3. A mask, a fluid shield mask or a gown shall be worn as described below:
  - 3.1. A Department-approved mask shall be worn whenever there is a suspected respiratory infection, whenever the patient or EMT is coughing, whenever the patient exhibits signs or symptoms of tuberculosis, or whenever the patient has an obvious rash. Note: Beards and/or mustaches may diminish the effectiveness of the mask.
  - 3.2. A gown shall be worn whenever there is the potential of gross contamination from blood or bodily fluids.
  - 3.3. A fluid shield mask shall be worn whenever there is the possibility of contamination of the mucous membrane of the eye, nose or mouth by means of a splash or aerosolization of bodily fluids. A fluid shield mask shall be worn while inserting an airway, performing intubation, suctioning a patient, or assisting in childbirth. A fluid shield mask shall also be worn whenever cleaning equipment that is contaminated with blood or bodily fluids.
4. After each use, if contaminated with blood or bodily fluids, gloves, fluid shield masks, masks and gowns shall be discarded as hazardous infectious waste.
5. A member treating a patient who exhibits signs and symptoms of a respiratory infection or an obvious body rash shall apply an N-95 isolation mask to the patient's face unless it would compromise patient care.
6. Latex-free supplies are stocked on all ambulances.

## UNPROTECTED EXPOSURE; REPORTING PROCEDURE

1. "Unprotected exposure shall mean an exposure capable of transmitting an infectious disease dangerous to the public health and is limited to the following:
  - 1.1. Puncture Wounds - including punctures resulting from used needles, glass and other sharp objects contaminated with blood, or human bites.

- 1.2. Blood to blood contact through open wounds which includes open cuts, sores, rashes, abrasions or conditions which interrupt skin integrity; and
- 1.3. Mucous membrane contact - including such contact as would occur with mouth-to-mouth resuscitation or eye splashing with infected fluids. Such fluids would include: blood, sputum, oral and nasal secretions.” (105 CMR 172.001)
2. If an unprotected exposure occurs, the affected area should be thoroughly washed as soon as possible. The Shift Commander and the Designated Infection Control Officer shall be notified. If the Shift Commander is not available, the on-call manager shall be paged. The following paperwork shall be completed for each unprotected exposure:
  - 2.1. The Boston EMS Unprotected Exposure Report completed by Field Lieutenant.
  - 2.2. The Massachusetts Department of Public Health Unprotected Exposure Report completed by the employee.
  - 2.3. The Worker’s Compensation Form - completed by the employee.
3. The following procedures shall be in effect:
  - 3.1. An employee who has been exposed shall contact the Field Lieutenant.
  - 3.2. The employee shall complete the Massachusetts Department of Public Health Unprotected Exposure Report and the Worker’s Compensation Form. The employee shall use 767 Albany Street as his or her home address. The Field Lieutenant shall complete the Boston EMS Unprotected Exposure Report. The original of the Department of Public Health Unprotected Exposure Report shall be left with the designated person at the emergency department.
  - 3.3. The Field Lieutenant shall fax a copy of the Department of Public Health Unprotected Exposure Report and the Worker’s Compensation Form to the Occupational Health Program at 617 638-8406. The employee shall then call the Occupational Health Program at 617 638-8400 as soon as possible to make a follow-up appointment if required. The follow-up appointment shall be made as a continuation of the employee’s work shift, i.e., before the start or after the end of the work shift. The Occupational Health Program is open Monday through Friday from 8:00 to 4:00 PM.
  - 3.4. In the event that the employee requires immediate treatment for the exposure and the Occupational Health Program is closed, the employee shall be seen at the Boston Medical Center-Menino Emergency Department. However, in the event of a known blood splash in the eye, the employee may be treated at the hospital to which the patient is transported for immediate evaluation, irrigation and other therapy.
  - 3.5. The Field Lieutenant shall respond to the Emergency Department at which the employee is being treated. The Field Lieutenant shall ensure that the Department of Public Health Unprotected Exposure Report and the Worker’s Compensation Form have been completed, and that the Occupational Health Program has been notified of the exposure by voice mail. The Lieutenant shall note this on the Supervisor’s Shift Summary. The Lieutenant shall send a copy of the Department of Public Health Unprotected Exposure Report and the Boston EMS Unprotected Exposure Report to the Designated Infection Control Officer. The Lieutenant shall also send the original Worker’s Compensation Form to EMS Headquarters addressed to the “Worker’s Compensation Coordinator.”
  - 3.6. If the employee does not require immediate treatment, the Field Lieutenant shall meet with the employee as soon as possible but before the end of the work shift. The Lieutenant shall confirm that the Department of Public Health Unprotected Exposure Report and the Worker’ Compensation Form have been completed and faxed to the

Occupational Health Program. The Lieutenant shall complete the Boston EMS Unprotected Exposure Report and forward all paperwork as described in the preceding paragraph (5).

- 3.7. The EMS Supervisor shall complete a Boston EMS Exposure report detailing the circumstances of the exposure, whether or not appropriate precautions had been taken to prevent or minimize the exposure, and recommendations for the prevention of similar occurrences in the future. The report will then be forwarded to the Designated Infection Control Officer who will review the report, ensure appropriate follow-up appointments have been made and make additional comments or recommendations as necessary.
4. Whenever a receiving hospital notifies the Designated Infection Control Officer that a patient has been diagnosed with an infectious disease, the Designated Infection Control Officer shall contact the affected members as soon as possible.
5. Whenever the Dispatch Operations Center Supervisor receives a call from a hospital that a member may have been exposed to an infectious disease, the Supervisor shall notify the Designated Infection Control Officer and the Shift Commander.
6. A member requesting information about a patient relative to an infectious disease shall notify the Designated Infection Control Officer who will contact the receiving hospital for follow up, and inform the interested member of the results of such inquiry whenever possible.
7. Although not considered an exposure, if a member transports a patient with lice and/or scabies and there is significant contact (i.e. exposed skin to exposed skin contact), the member shall page the Designated Infection Control Officer.
8. The Designated Infection Control Officer shall maintain records regarding employee exposures. The information shall be recorded and maintained in such manner as to protect the confidentiality of the injured employee.

#### SHARPS

1. Boston EMS has implemented a “needleless” system and utilizes sharps designed with built-in safety features or mechanisms that effectively reduces the risk of an exposure incident. However, EMS personnel may still encounter contaminated needles at the scene of a drug overdose, patient’s home, health care facility, or other location. When disposing of a sharp, needles shall not be recapped, bent or cut. The syringe, with or without the needle covered, shall be discarded in either the needle box supplied in each ambulance or the needle box carried inside all Department- issued ALS jump bags. Replacement containers are procured from Material/Facility Management. All syringes/needles shall be removed from the scene of an incident and discarded in these containers.
2. All ambulances- ALS and BLS- are supplied with needle boxes. The needle boxes shall be secured either by an adhesive pad or within a bracket mounted near the point of use. All units shall discard used needle boxes at a receiving facility whenever the box is more than half-filled.
3. After intravenous angiocatheter insertion, the vacutainer system shall be attached for drawing bloods, and filling blood tubes. A needle and syringe shall not be used for filling blood tubes.
4. A needle venipuncture shall not be performed to obtain blood samples.
5. If a patient is encountered who has a needle in an extremity or other body part, the needle shall be removed and discarded in the needle box.

## ROUTINE CLEANING

1. The ambulance crew shall be responsible for maintaining a clean ambulance. All areas of the patient compartment that may come in contact with a patient's blood or bodily fluids such as the walls, floors, seats, grab rails, stretchers, etc., shall be wiped clean of obvious debris with a Department-approved disinfectant.
2. When doing an interior wash, all equipment/supplies will be removed from shelves and cabinets. The shelves and inside cabinets shall be cleaned with a Department approved bleach equivalent disinfectant.
3. Whenever any equipment has come in contact with blood/body fluids, it shall be cleaned and disinfected by the ambulance crew immediately after the disposition of the patient. All obvious debris shall be removed, and the items shall then be thoroughly cleaned with a Department approved bleach equivalent disinfectant.

## CLEANING ALL OTHER EQUIPMENT

Department members shall wear gloves while decontaminating equipment. Fluid shield masks shall be used if splashing is anticipated. Equipment shall only be decontaminated in areas that are designated as appropriate by the facility and/or staff. After patient contact, the equipment listed below shall be cleaned of all obvious debris before being sent to Material/Facility Management for high-level disinfection. Once grossly decontaminated, the equipment shall be placed inside a red hazardous waste plastic bag. This bag shall be stored in the outside rear compartment on the passenger side of the ambulance until exchanged or replaced.

- All Bag-Valve Masks
- Suction Equipment (except suction catheters which are disposable)
- Intubation and non-disposable airway equipment
- Any other contaminated equipment (stretcher straps, oxygen bags, etc.)

## DISPOSAL OF NON-SHARP HAZARDOUS INFECTIOUS WASTE

The term "hazardous infectious waste" (H.I.W.) means waste material with infectious characteristics causing or contributing to an increase in mortality, serious irreversible illness, or incapacitating reversible illness. It may also pose a hazard to human health or the environment when improperly treated, stored, transported, disposed of, or otherwise mismanaged. All hazardous or patient generated waste shall be disposed of at the receiving facility. Expendable non-sharp materials that have come in contact with a patient's blood or body fluid shall be sealed in two 3 mil (3/1000 inch) polyethylene bags. Each bag shall be sealed separately, and the outer bag shall be the red hazardous waste plastic precaution bag. These bags are stocked on board the ambulance. These sealed bags must be leak free from liquids and/or vapors. The sealed bag(s) shall be disposed of in the hazardous waste receptacle as soon as possible.

*Related: 105 CMR 172.000: Regulating the Reporting of Infectious Diseases Dangerous to the Public Health; Unprotected Exposure form available on-line at: <http://www.mass.gov/dph/oems/forms/unprotx.doc>); Latex Free Kit*

## APPENDIX A: First Responder / Resource Agencies

### **Boston Fire Department**

The Boston Fire Department is an organization of dedicated professionals who are committed to serving the community by protecting life, property, and the environment through prevention, education, emergency medical and fire services. The Boston Fire Department will provide fire protection and emergency services throughout the City of Boston by adequately staffing, training, and equipping firefighters at specific locations within the City.

The Boston Fire Department maintains 33 Engine, 21 Ladders, 2 Heavy Rescues, a Marine Unit, and other specialty units. These units are staffed by approximately 1600 uniformed firefighters trained and authorized to function at the AED / first responder level on EMS responses. The Boston Fire Department is the service zone's primary first responder agency.

### **MassPort Fire Rescue**

The Massport Fire Department has a force of 85 members. One engine, 1 ladder, 1 heavy rescue, and 5 crash rescue units respond from 2 fire stations at Logan International Airport and average over 3,300 runs annually. Massport Fire Department units are equipped with AEDs and staffed with personnel trained in their use. MassPort Fire Department responds to assist at all medical emergencies on MassPort property at Logan International airport.

### **Boston Police Department**

The Boston Police Department, the oldest police department in the country, has approximately 2,000 uniformed officers trained at the first responder level. The BPD currently is divided into 11 precinct districts, each with its own District Commander. The BPD deploys many specialized units, including its Special Operations Unit, Harbor Patrol and Dive Unit, Domestic Violence Unit, Sexual Assault Unit, Mounted Unit, and a Crime Lab Unit.

The BPD has field officers in one and two person patrol units (704), as well as motorcycles (68), bicycles, watercraft (9) and mounted patrol (12). This mix of response modalities enhances BPD access to all areas of the City and makes them an effective adjunct to EMS delivery as well as providing the necessary support to EMS personnel at hazardous environments.

BPD Headquarters is located at 1 Schroeder Plaza and houses the PSAP and dispatch (CAD) centers for both BPD & BEMS. Boston EMS Communications Section employees staff the EMS section of the communications center.

### **Boston MedFlight**

Boston MedFlight (BMF) is a Commission on Accreditation of Medical Transport Systems (CAMTS) accredited Critical Care Transport service which utilizes three helicopters, a fixed wing aircraft as well as two critical care ground vehicles. BMF is the only program in the New England area that utilizes all three modes of transportation. BMF's mission is to extend the tertiary care services of the major Boston hospitals to the citizens of Massachusetts and New England. The service is available 24 hours a day and seven days a week. Since 1985, Boston MedFlight has played an integral role as part of the Massachusetts and New England EMS

systems and the community hospitals of New England. BMF is affiliated with the six major teaching hospitals in Boston (MGH, B&W, Boston Children's, NEMC, BMC and BI).

### **United States Coast Guard**

During the past several years, the facilities of the 1<sup>st</sup> District of the United States Coast Guard (USCG) have upgraded their communications capabilities to include the insertion of the VHF frequency 155.280 MHz into the radios of most of their fleet of rescue boats, cutters and aircraft. With this frequency, the USCG is better able to handle medical emergencies that occur at sea by allowing them to contact area hospitals through Boston CMED.

During a natural or man-made disaster, Boston C-MED may well be the only link between civilian rescuers and USCG units involved in disaster management. The USCG Air Station at Otis Air Force Base in Falmouth is now in the process of upgrading their airborne radio equipment to allow them to contact Boston C-MED for ALS medical direction on the UHF frequencies. This will be accomplished by the use of low-power portable radios connected to external antennae on the aircraft.

1. Through an agreement between the USCG and the New England Medical Service Council, all CMEDs should be capable of assisting the Coast Guard during offshore search and rescue (SAR) missions. Boston C-MED operators should be ready to give advice as to what types of medical facilities are best suited to certain types of injuries, but the final decision as to the immediate course of treatment and ultimate destination of the patient should be made by the physician on duty at the medical control facility nearest the Coast Guard unit.
2. Boston C-MED operators should be aware of possible aircraft landing sites in the area, and be ready to alert local EMS agencies and/or fire departments to provide fire/crash/rescue support and ground transportation when needed.
3. When Boston C-MED is contacted by a USCG unit, the radio traffic should be handled in a manner similar to that of other field providers.
4. A list of USCG facilities and telephone numbers will be maintained at both the Dispatch Operations Supervisor area and C-MED consoles for reference as the need arises.

### **Regional MCI Trailers**

Several Regional MCI Support Trailers have been strategically located throughout the Commonwealth (listed below) to provide equipment and supplies to EMS personnel at the scene of a mass-casualty incident (MCI). Pre-hospital EMS providers will notify their regional C-MED center to request deployment of an MCI Support trailer.

Upon request, the Dispatch Operations Division, in conjunction with Boston C-MED, will provide logistical support to personnel at the scene of an incident occurring and/or terminating within EMS Region IV, or to other C-MEDs for incidents occurring outside of EMS Region IV.

1. The Dispatch Operations Supervisor shall be notified of any calls requesting MCI Support Trailer assistance. The Dispatch Operations Supervisor or designee shall coordinate communication and deployment of support resources, relaying all necessary information to the participating agencies and C-MEDs as appropriate.

2. Upon receipt of a request for an MCI Equipment Trailer, the supervisor and/or designee shall determine the following:
  - Name and contact information for the agency making the request;
  - Name and contact information of the coordinating agency (if not the same);
  - Location, incident type and projected number of casualties;
  - STAGING location to deploy the trailer, and any special conditions or hazards; and
  - Radio frequency or channel name the incident is operating on.
3. The Supervisor shall then determine the closest available MCI Support Trailer, provide them incident information (from #2) and determine their ETA to the incident. The requesting agency will then be notified which MCI Support Trailer is responding, and their ETA to the incident.

## APPENDIX B: Supporting / Sample Documentation

### Mutual Aid Agreement



The parties have entered this agreement for emergency back-up ambulance service in accordance with 105 CMR 170.385 (Service Availability and Backup) to provide, through their mutual cooperation, a pre-determined plan by which each might render aid to the other in case of an emergency which demands emergency ambulance services to a degree beyond the existing capability of the requesting party. It is agreed this (date), by and between (name) Ambulance Service, Inc. of (town), Massachusetts, (hereinafter “abbreviation”) and the Boston Public Health Commission through its Boston Emergency Medical Services division (hereinafter “Boston EMS”) that:

1. Upon request, each party shall provide the other with back-up ambulance service at the Advanced Life Support and/or Basic Life Support level in accordance with all Federal, State, and local regulations whenever they have an ambulance or ambulances available to respond. If the party who receives a request for back-up ambulance service pursuant to this agreement does not have an ambulance available to respond, they shall so advise the party requesting back-up immediately and deny the request.
2. Requests from Boston EMS to (abbreviation) for back-up ambulance service shall be made by calling (phone #), 24 hours a day, 365 days a year. Requests from (abbreviation) to Boston EMS for such service shall be made by calling (617) 343-45XX, 24 hours a day, 365 days a year.
3. The personnel of the party responding to a request for back-up ambulance service pursuant to this agreement shall not be considered agents or employees of the party requesting back-up service.
4. The party responding to a request for back-up ambulance service pursuant to this agreement shall ensure that its personnel drive their vehicles in compliance with all laws regarding speed and with due regard for the safety of all persons using the roadway.
5. The party responding to a request for back-up ambulance service pursuant to this agreement shall be exclusively liable for any and all injury or damage caused by the acts and omissions of its personnel and shall hold the party that requested back-up and its employees harmless from all suits and claims against them arising from such acts and omissions except that the Boston Public Health Commission and its employees (including all members of Boston

EMS) shall be subject to the provisions of M.G.L. c. 258, including but not limited to the immunity and liability limitations therein.

6. The party requesting back-up ambulance service shall not be liable to the party responding to a request pursuant to this agreement or that party's agents or employees for property that is lost, stolen, or damaged in the course of responding to the request.
7. Each party shall be solely responsible for billing the private payer or appropriate third party for services it renders pursuant to this agreement. The parties shall not be liable to each other for services under any circumstances.
8. The parties agree to utilize the Incident Command System to provide structure for incident management so as to assure efficient use of resources and the safety of emergency responders and patients. The EMS Incident Commander in whose jurisdiction the emergency exists shall in all instances be in command of the emergency as to strategy, tactics, and overall directions of the EMS operations.
9. Upon completion of a call, the party responding to a request for back-up ambulance service pursuant to this agreement shall notify the party that requested back-up service of all times relative to the call (on scene, transport, transport complete), the call's disposition (transport, patient refusal, no visible incident, etc.), and any noteworthy information.
10. This written agreement constitutes the entire agreement between the parties, and its terms shall not be altered, amended, or waived without the express written agreement of both parties.
11. This agreement shall be effective from the date of execution, and shall remain in effect unless either party terminates the agreement in accordance with this paragraph. Either party may terminate the agreement for convenience or any other reason by giving the other party thirty (30) days advance written notice.

### **CMED Communication Network**

The statewide EMS radio network is comprised of discrete regional radio systems. Each system has the following components: a CMED center, associated ambulance services, hospitals, rescue squads and municipal agencies. The system is designed to meet local needs but adhere to a common design strategy that will afford compatibility across regional boundaries and the interconnection of systems into the statewide network. Operational and medical communications are primarily accomplished via two-way land mobile radio, which usually operates on two bands: very high frequency (VHF) and ultra high frequency (UHF). Utilization shall be as follows:

155.280 MHz	Point-to-Point coordinating frequency and mass casualty channel.
155.340 MHz	Ambulance-to-Hospital channel
462.950/467.950 MHz	"TAC-9", Intrasystem coordinating and on-scene working/triage channel
463.000/468.000 MHz	("MED-1") Ambulance-to-Hospital channels

463.025/468.025 MHz	("MED-2")
463.050/468.050 MHz	("MED-3")
463.075/468.075 MHz	("MED-4") Common calling and coordination channel
463.100/468.100 MHz	("MED-5") Ambulance-to-Hospital channels
463.125/468.125 MHz	("MED-6")
463.150/468.150 MHz	("MED-7")
463.175/468.175 MHz	("MED-8")

**BIOMEDICAL CHANNEL UTILIZATION AND ALLOCATION PLAN**

Massachusetts uses a planned utilization of the medical channels, which includes a “common calling” channel (MED-4), a “critical” channel that is not duplicated with adjacent systems, “secondary” channels that are shared and “overflow” channels. Assignments for the channels are made by the Department of Public Health for each system prospectively with the shared channels to be used according to the principles of real-time sharing.

The utilization plan is intended to:

- Make maximum use of all channels in a spectrum-efficient manner;
- Ensure that at least one channel per system is substantially free of co-channel interference from neighboring systems and thus can be relied on for communications of the most critical nature. Systems must endeavor to fully utilize their critical channels, for only the top priority uses resulting in low loading levels are contrary to the concept of critical channel utilization.

**Channel utilization is defined below:**

Common Calling Channel (MED-4; all systems)

UHF-equipped EMS units shall obtain channel coordination from Boston CMED by first calling on MED-4, advising Boston CMED of the unit’s location and needs and following the instructions of CMED.

Critical Channel

Critical channel use will follow specific system policies and CMED operator discretion. In general, the system’s more important communications should take place on this channel. Loading of the channel should be as full as practical. CMED operators should attempt to shift concurrent traffic taking place on a shared channel to the critical channel as it becomes available.

*Shared Channel*

These channels may be utilized by adjacent systems. Monitoring of the channel to determine its availability shall always precede assignment of a channel by CMED. Short notifications by basic EMS units may be assigned a shared channel directly, even when the critical channel is free, provided that the system’s overall utilization of the critical channel remains high. CMED to CMED coordination of shared channels on a real-time basis through the use of 155.280 MHz is encouraged.

*Overflow Channels*

One system’s overflow channels will be the adjacent systems’ critical channels. Utilization of an overflow channel shall be only when absolutely necessary and the communication can not be delayed. Use of an overflow channel must be ended no later than 60 seconds following the

availability of a critical or shared channel within the system. The field unit shall be instructed to shift channels at the first opportunity.

For purposes of discussion, Boston CMED’s channel utilization plan is as follows:

<b>Description</b>	<b>Med Channel</b>
Common Calling	4
Critical	3
Shared	6, 8, 5
Overflow	7, 1, 2

Utilization of shared channels should be according to the listed order. The first channel should be used most heavily of the shared group, the last used the least.

*METRO-BOSTON CMED*

Boston CMED provides for the coordination of EMS telecommunications in the region. The center is staffed 24 hours a day with specifically trained EMT-Telecommunicators. Boston CMED is responsible for coordinating communications for 62 cities and towns (Region IV). Listed below are a few of the functions of Boston CMED:

- Manage EMS channel usage within the region.
- Coordinate channel management with neighboring CMEDs as a part of the statewide network.
- Serve as a clearinghouse for EMS resource status information (e.g., emergency room diversions, loading, bed status, specialty care facilities, ambulances, etc.).
- Monitor the radio traffic to determine the quantity and quality of transmissions and to detect and resolve outages.
- Provide Command/Control/Communications/Intelligence (C<sup>3</sup>I) functions during mass casualty or disaster responses in cooperation with authorized scene commanders and medical control physicians.
- Coordinate EMS with other public safety agencies through the use of radio channel patch capabilities.
- Provide general assistance as requested by any EMS agency in accordance with system procedures.
- Aid out-of-region (“foreign”) ambulances and other EMS units entering or passing through the region.

*System Elements*

EMS Provider agencies in the Metropolitan Boston region utilize both UHF and VHF band radios to coordinate field operations and medical direction. The communications system that employs these radios also includes special telephone and microwave links for interconnection of certain fixed points. Basic components of a communications system generally include (1) portable and mobile transceivers; (2) base stations; and (3) central and remote control consoles.

*Special Features*

Operationally, this design provides total control of base stations and mobile relays so that interference and extraneous signals are minimized. More importantly, this centralization allows

functions such as radio-telephone crosspatching, UHF/VHF crossbanding and dynamic channel assignments to be performed.

This EMS communications system is designed for maximum technical efficiency and channel utilization. However, the system's efficiency is primarily a function of how the user verbally communicates his information. With this in mind, this protocol for communications has been written to assist the Basic EMT, Advanced EMT, emergency department nurse and medical control physician in operating an EMS radio.

*Dedicated Network*

*CMED Responsibility*

Radio communications which concern any of the Metro Boston network hospitals should be coordinated by the designated network control station ("Boston CMED"). CMED is responsible for continually monitoring and expediting radio traffic to keep the network operating efficiently. All UHF communications between field units and hospitals, and those VHF communications to and from hospitals that do not possess VHF equipment, shall be directed to CMED for the particular frequency being used, or agency being called upon. VHF communications concerning Basic Life Support activities between field units and hospitals equipped with VHF radios shall be direct and on 155.340 MHz.

*Radio Frequencies*

*Tone Squelch Assignments for UHF Radio Equipment*

Metro Boston:	151.4 Hz
Statewide:	192.8 Hz

*Digital Dial and Touch-Tone™ Squelch for VHF Radio Equipment*

Boston CMED:	3100
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*Point-to-Point Communications*

- Point-to-Point communications for coordination of critical transfers, mutual assistance and mass casualty incident management will normally be conducted on VHF radio frequency 155.280 MHz.
- Coordination of Intersystem MED-channel assignments shall be conducted on MED-channel FOUR by monitoring the co-user base station transmit frequency (463.075 MHz). While communications between CMED centers is normally restricted to the VHF frequency 155.280MHz, certain emergencies will permit the use of MED-4 for coordination purposes.
- Where capabilities exist, point-to-point communications may be conducted on remote radio control lines or microwave audio sub-carrier channels.
- Where VHF radio frequency 155.280 MHz is not available at certain resource coordination centers, frequency 155.340 MHz may be used for intersystem coordination.

## GENERAL PROCEDURES

### *F.C.C Rules*

The applicable rules and regulations of the Federal Communications Commission shall govern the general operation of the EMS radio channels.

### *Monitor Frequency*

All persons operating EMS radios must monitor the frequency on which they desire to operate, prior to transmitting.

### *Transmitting Names*

All communications shall be kept impersonal. When names are transmitted, the full name or last name with title only shall be used. Names may also be substituted for call signs.

In order to maintain patient privacy rights, patient names shall not be transmitted except in cases of extreme emergency, and only when the conduct of the medical care to be provided requires specific patient identification. Only medical personnel at a hospital may determine that a patient's name needs to be transmitted.

### *Identify Every Transmission*

Unit identifiers are to be said in every transmission.

### Intonation and Voice Level

Word or voice inflections that reflect irritation, disgust or sarcasm must not be used. Relations with other users shall remain cordial at all times. Do not yell under any circumstances.

### *Message Brevity*

All messages shall be kept brief and to the point.

### *Answering Radio Calls*

All radio calls must be answered. When busy with patient care activities or traffic on another channel, the phrase "STAND-BY" shall be used to indicate receipt of call and intent to answer when available.

### *Radio unit Identifiers*

Every user should utilize an ID consistent with these procedures. Each ID shall have a short and long form. The long form of an ID shall be used when initially establishing contact with another unit. The short form may be used to enable brevity through the balance of a message. When in doubt, use the long form ID

### *Composition*

Radio unit identifiers shall be issued by the Commanding Officer of the Boston EMS Dispatch Operations Division, or his designee. Identifiers shall be alphanumeric characters or proper names of persons, hospitals or geographic locations. Examples:

Long Form	Short Form
North Shore CMED Center	North Shore
Worcester CMED Center	Worcester
Massachusetts General Hospital	MGH
Boston Medical Center-Menino	BMCM

*Mobile Units*

A mobile (or portable) unit may be an ambulance, a paramedic squad or an EMS supervisor. Mobiles and their corresponding portables shall incorporate a number in their ID; the short form ID being the number alone. The first digit of the number will correspond to the unit’s region; the succeeding digits will be assigned according to a regional plan that meets local needs.

*Personnel Identifiers*

All medical control communications will identify EMS personnel by an assigned ID in addition to the use of unit ID’s. BLS units requesting consultation (advice) shall also use personnel ID’s. After initial contact has been made by using the long form unit ID, communicating personnel shall use their personnel ID instead of the short form unit ID.

Examples:

EMT Jones	For a Basic EMT
Paramedic Jones	For an EMT-P
RN Jones	For a nurse
Dr Jones	For a physician

Regions and/or locales may opt for assigning numbers in place of surnames. The level of certification should still precede such a number for the complete (long form) identifier; e.g. "Paramedic 123".

*Purpose of Call Signs*

According to F.C.C. rules, call signs are to be used as identification. In addition, unit identifiers will be used at the beginning of a transmission to prompt the voice-actuation circuits in a “patch” condition. Any unit (i.e., two-way radio) must be authorized for use by an F.C.C. license. Mobile and portable units are typically authorized under a base station or system license. In such instances, the unit identifier may be used alone. Base stations located at hospitals (VHF) or stations operated in a system with a C-MED Center (VHF and UHF) shall normally say the call sign at the close of a series of transmissions.

Example:

“4-2-2-2, Metro Boston CMED. Roger your arrival at MGH. This is KIR-735, Boston CMED, out.”

*Language Format*

These procedures endorse the principal that Plain English, coupled with accepted medical terminology, is the surest way to accomplish effective communications, either via radio, telephone or in person. This document lists preferred terms or phrases that have been shown to be particularly effective. EMS personnel are encouraged to routinely use these terms. Except for Priority Codes, radio codes are discouraged as a rule. Should local needs dictate the use of codes they should be minimized. In such areas, EMS personnel should be capable of switching to a code-free message when operations demand communications with non-local hospitals, ambulances or CMEDs.

## CALLING PROCEDURE

### *Procedure When Requesting Channel Assignment and/or Radio Patch*

Field providers hailing CMED on MED channel 4 should always note their proper Unit ID and physical location. For example “Metro-Boston CMED, this is Framingham Paramedic 1 on Rte 9 in Framingham calling”. The CMED operator will answer the unit on the correct base station and clearly state “Framingham P-1, this is Metro-Boston CMED, go ahead”. Once acknowledged by the CMED operator, the field unit will then proceed with their request: “Metro-Boston CMED, this if Framingham Paramedic 1 requesting a Priority 2 entry note to Metro-West Framingham”. The CMED Operator will then acknowledge the request and direct the unit to a specific medical channel. “Framingham P1 from Metro-Boston CMED: please shift to MED 7 for your entry note to Metro-West Framingham.”

Using the above procedure will help prevent confusion when multiple units simultaneously call CMED. This specific information is essential for each call, as it allows the CMED operator to quickly and easily: 1) know which unit to answer, 2) which base station to use (for best coverage), and 3) how to prioritize radio traffic when handling multiple, simultaneous requests.

### *Initial Contact With a Hospital*

When calling a station, say the name of the station or unit you are calling, followed by the words, “This is” and then your call sign, ending with the proword “OVER.”

“Carney Hospital, this is Medic One Ten, over.”

### *Answering Procedure*

To answer a call, use the same procedure as described above.

### *Message Precedence*

In order to distinguish between routine message and those which require immediate action, the following prowords shall be used (as necessary) to identify the priority of the radio traffic which is to be transmitted.

PROWORD	MEANING
“Priority One”	Communications concerning a life-threatening condition, requiring an immediate patch to a hospital.
“Priority Two”	Communications concerning a potentially life-threatening condition, requiring a patch as soon as possible.
“Priority Three”	Communications concerning conditions which are not life-threatening, requiring a patch as soon as possible.
“Priority Four”	Communications which are administrative or informational only.

Whenever possible, Priority Four traffic should be relayed through a local dispatcher and then by telephone so as to avoid unnecessary congestion of the system.

Note: Most Boston hospitals do not require Priority Three notifications. Conference of Boston Teaching Hospitals (COBTH) policy states that no Boston hospital shall require Priority Four notifications.

*Acknowledging Messages*

Messages should be acknowledged by saying the unit identifier, the proword “ROGER” and repeating the essential parts of the text of the message back. If there is a question as to whether or not the received message is correct, the proword “CONFIRMED” shall be said at the end of the message when repeated.

*Prowords and Phrases*

Experience has proven that some words when spoken over a two-way radio can be easily confused with other words and result in disastrous miscommunication. The words and phrases in this list are ideal for avoiding this type of problem and all radio users should become comfortable with their use.

<b>Word or Phrase</b>	<b>Definition (for radio use)</b>
ACKNOWLEDGED	I have received your message and will act upon it.
ACUTE	Condition of rapid onset.
AFFIRMATIVE	Yes. (Spoken over a radio, “yes” is easily confused).
ARRIVAL	Unit has arrived at its intended destination.
ASSIGNMENT	Assignment to an incident or radio channel.
BREAK	To interrupt in an emergency, or to separate parts of a group of messages.
CALIBRATION	A telemetry signal that when transmitted produces a 1mv output at the EKG display. (Similar to “standardizing” an EKG strip)
CHANNEL (e.g. MED 1)	The radio frequency or pair of frequencies used in a radio system.
CONTACT	Establish communications.
CLEAR	Available; I am terminating this communication (or incident).
DISREGARD	Do not take action on last transmission.
ENGAGED/DISENGAGED	Radio patch connected/disconnected.
ENROUTE	Traveling to a specified destination.
FREQUENCY	The technical expression of an electronic signal expressed in cycles-per-second (cps), or hertz (Hz), or megahertz (MHz) of a base-line signal. In general use frequency refers to the signal used in a radio system. (E.g., 155.340 MHz, or tone code

	7A~192.8 cps).
HOLD	Remain at present location or specified position.
INCIDENT	An emergency at which EMS is required.
INCORRECT	Wrong.
LANDLINE	Order to make call by phone or refers to telephone company supplied circuits that connect a radio system.
MONITOR	Listen to all traffic on a radio channel.
NEGATIVE	No.
OBTAIN	Get.
OUT	I have finished all messages, do not expect a replay and the channel is open to others.
OVER	I have finished my message and expect a reply from you.
QUIET RESPONSE	Without use of siren.
RELAY	Pass the traffic on to another person or station (repeat message verbatim).
ROGER	As in acknowledge, I have received your message and will act on it.
REPEAT	Administer the indicated therapy an additional time. (See SAY AGAIN).
SAY AGAIN	Repeat the last message transmitted. (Not to be confused with REPEAT).
SHIFT	Change channel as ordered.
SHIFT AND ACKNOWLEDGE	Change channel as instructed and say on the new channel your ID and acknowledge the shift.
SHIFT AND CONTACT	Change channel as instructed and call the desired station.
SHIFT AND STANDBY	Change channel as instructed and listen for further traffic.
STAND-BY	Answer to request is not immediately available, or user is busy with competing traffic. The order stand-by implies that a unit should stay on channel until called upon; order should not be acknowledged.
STATUS	A unit's present activity.

TRAFFIC Messages transmitted by radio between units and/or stations.

TRANSPORT Commence transportation of a patient by ambulance.

*Transmitting Numbers*

In order to avoid errors when measurements of medications are ordered, or addresses are transmitted, numbers should be transmitted DIGIT-BY-DIGIT and pronounced as described below:

1	“WUN”	Strong W and N
2	“TOO”	Strong and long OO
3	“THA-REE”	Strong TH and R
4	“FOWER”	Strong O, Strong W and Final R
5	“FIE-YIV”	Strong I changing to Strong Y and V
6	“SIKS”	Strong S and KS
7	“SEV-VEN”	Strong S and V
8	“ATE”	Strong A and long T
9	“NINER”	Strong NI and sounded ER
0	“ZEE-RO”	Strong Z and Short RO

*Transmitting Directions*

When transmitting directions by radio, providers should use proper names and avoid using slang or abbreviations, particularly when describing locations. Use specific instructions, said in phrases, such as “PROCEED TO”, “TURN”, “HOLD”, “MONITOR”, “ADMINISTER”, etc.

**MEDICAL COMMUNICATIONS**

Medical communications, and medical consultation refer to communications which take place between the field and hospital, or the field, specialty center and hospital. Whether the communications are to direct ALS treatment, support the Basic Life Support effort, or exchange critical patient care data, the communications must be accurate if they are to be effective.

In the following paragraphs are guidelines that essentially create the structure for reporting and exchanging patient data and clinical information. These guidelines have been written with consideration that medical communications are lengthy in duration and are often much more detailed than dispatch or operational traffic. Throughout this chapter, special phrases and radio prowords are used to facilitate brevity; however, the main concern is that the communicating parties clearly understand each other.

The primary goal in communicating clinical information by radio is to assist the nurse and/or physician decision-maker. In order to provide this assistance, the EMT, Advanced EMT and EMS Supervisor must communicate his information clearly, directly, and in an objective manner to create an accurate mental picture for the nurse or physician.

Secondarily, structured medical communications supports the transition between first responder, EMT, Advanced EMT, nurse and physician provider. In a sense, the guidelines that follow create a context for the entire system to communicate the patient’s condition to the next level of care.

### *Coordination and Monitoring of Medical Traffic*

All Advanced Life Support communications concerning patient care, ambulance transportation to the hospital, point-of-entry and hospital-to-hospital traffic shall be coordinated by the communications coordinating center, "CMED."

The CMED Operator shall assign channels, activate hospital remote control stations, alert medical control physicians and continually monitor the voice and telemetry signals to ensure reliability of the communications in progress. In addition, he will collect and maintain status data on hospital resources, supervise point-of-entry plans and, in general, be responsible for establishing the communications required between the field and the hospitals.

## MEDICAL CONTROL

### *Receiving Hospital Conference*

Ambulances transporting patients under medical control shall notify the receiving hospital as soon as is practical during transport. As necessary, or as directed by Medical Control, the hospital receiving the patient may confer with the Medical Control Physician.

### *EKG Telemetry*

The use of EKG telemetry will be in conformance with the Statewide "Advanced Life Support Pre-Hospital Clinical Protocols."

Individual transmissions of EKG telemetry signals shall not last longer than 30 seconds. Medical Control will request repeat transmissions as often as is felt to be appropriate.

### *General Overview of Patient Report*

Radio medical reports will always be concise and as brief as possible. They do not replace nor are they the same as a complete run report that is transferred in writing and/or orally after arrival at a hospital. Patient Care Reports include much information that, while important, should not be communicated by radio. Any prolonged communication must contain periodic breaks in the transmission so that other users who have a need to communicate can be detected.

## PATIENT NAMES

In order to respect patient confidentiality, patient names must not be routinely transmitted over the air. In rare instances, and only as a last resort, a patient's name may be transmitted if there is a medical reason that will directly affect patient care on arrival of that patient at the hospital. Only medical personnel at a hospital are appropriate to determine if there is a justifiable reason to request a name.

In general, ALS cases and Priority Ones and Twos will provide complete medical reports. Priority Three cases should normally limit the report to Age, Sex, and Chief Complaint followed by the ETA.

The presentation of a patient by radio or telephone requires that particular attention be paid to certain discrete areas. These are:

- Identification of the patient in terms of age, sex and a reference to the degree of distress.
- The chief complaint in a word or phrase.
- Present status in more specific terms; what body systems are affected or stressful.
- Pertinent negatives which are diagnostic.

- Past medical history.
- Medications.
- Physical findings to include vital signs.
- Treatment rendered thus far, to include transportation.

#### *Reference Assessment Procedures*

The presentation of a patient report by radio or telephone is a function of the initial assessment. An incomplete assessment leads to an incomplete communication, which in turn, leads to incomplete patient care. On the other hand, lengthy, rambling, unstructured presentations are a waste of time and often are as detrimental to the patient as a fragmented report. To reinforce the structure and completeness of the patient report, a thorough assessment is necessary. Become thoroughly familiar with these assessment procedures so that only pertinent data is communicated in your patient report.

#### *General Voice Procedures*

Avoid abbreviations that are not commonly used. Instead, use commonly accepted descriptive clinical terms.

Identify each transmission using identifiers, especially when acknowledging orders.

Acknowledge treatment orders by repeating them back exactly as you have received them.

Follow the order of the reporting format when transmitting a patient report

#### *Disaster Procedures*

Definitive disaster procedures are the responsibility of regional and local agencies. EMS users are expected to be thoroughly familiar with local procedures. These procedures include basic principles that should be common statewide.

Most “disasters” are mass casualty incidents (MCI) and as such only local units should be involved per local plans. True disasters may utilize foreign units but such units shall only participate when requested by the EMS agency in primary command. Local units by definition, have compatible communications, foreign units may not.

Ambulance response and scene command shall be conducted on a separate frequency from the one used for medical communications, if possible. Medical communications should be coordinated by a C-MED center or other party according to plan. Ambulances evacuating patients to hospitals shall be assigned by C-MED or scene commander and will not radio a full medical report.

Users of VHF channel 155.340 should respect that the channel will be in use in nearby areas for routine operations. MCI operations may not “take over” 155.340, thus interfering with communications in areas unaffected by the incident.

Hospital resources or other special needs not available regionally will be requested via an adjacent region’s C-MED. In most cases a local C-MED will be asked by an EMS commander to secure specified resources, such as burn beds. That local C-MED will contact an appropriate distant C-MED which will in turn poll for resources within its jurisdiction.

Prompt and repeated updates of an incident shall be communicated to all hospitals with a potential to receive patients and to nearby hospitals which may be indirectly impacted by an

MCI. The hospital will use such information and determine if its institutional disaster plan should be executed. All information should be qualified according to the degree of information needed to be transmitted.

Local ambulances with emergencies unconnected with an MCI in progress shall follow local procedure for such circumstance. Foreign units unknowingly encountering an area with a MCI shall be asked by the C-MED or hospital: "We have an MCI in progress, what is your priority?" If the Priority is Three or Four, the ambulance should be told to defer to another facility and/or discontinue further use of the communications channel(s). If the Priority is One or Two, the ambulance should be interrogated further to determine what is best for the patient considering the circumstances of the MCI. Critical patients should not be arbitrarily deferred.

Reference: This document is based on the "Massachusetts Emergency Medical Services Systems Communication Plan" which was adopted by the Department of Public Health's Emergency Medical Care Advisory Board in June, 1984

## **Protection of Confidential Health Information / HIPAA**

### **PURPOSE**

Each resident of the City of Boston and citizen of the Commonwealth has a fundamental right to privacy and confidentiality in his/her relationship with health care professionals and other entities that collect, use, or maintain confidential health information.

To further its mission, BPHC collects confidential health information for treatment, and use in public health surveillance, program development and evaluation, research, and for many other public health purposes. It is critical that BPHC staff and agents who carry out these core functions recognize the importance of protecting personal privacy and safeguarding the confidentiality of information obtained by BPHC to the greatest extent possible. To this end, BPHC adopts this Policy on Protection of Confidential Health Information.

This Policy is intended to ensure that BPHC staff (hereinafter includes but not limited to, employees, volunteers, contractors, agents) complies with all relevant state and federal laws and regulations concerning the protection of confidential health information. These include, but are not limited to, the Health Insurance Portability and Accountability Act (HIPAA), privacy and security regulations adopted pursuant to HIPAA, the Massachusetts Fair Information Practices Act (FIPA), and Massachusetts Executive Order #412.

### **POLICY PRINCIPLES**

This Policy is based on the following principles:

- A. **Accountability**. BPHC must be responsible for providing notice of this Policy and its requirements to its employees, volunteers, contractors, agents, and approved external researchers. Access to, use of and disclosure of confidential health information should be based on a legitimate need to know.
- B. **Openness**. Individuals should be given notice about how BPHC collects, uses, maintains, and discloses confidential health information.
- C. **Limiting Collection**. BPHC will collect the minimum amount of confidential health information necessary to enable BPHC to implement statutory and regulatory requirements,

effectively provide health care, create public awareness of factors affecting good health, or otherwise fulfill BPHC's mission.

D. **Limiting Use.** BPHC will only use confidential health information as necessary to fulfill BPHC's mission or as authorized by the client. BPHC will also limit internal access to such information only to those staff members with a need to know.

E. **Limiting Disclosure.** BPHC may disclose confidential health information when authorized by the client as necessary to fulfill BPHC's mission provided that such disclosure is not prohibited by law. Confidential health information should not be communicated externally without the authorization of the client except: 1) in accordance with applicable research protocols established by BPHC; 2) when sharing client health information with a direct care provider of the client; 3) for payment purposes; or 4) when otherwise permitted by law or regulations.

F. **Integrity.** BPHC shall endeavor to ensure the quality, accuracy, thoroughness, and reliability of confidential health information under its control, whether in written, electronic, or other form.

G. **Individual Access.** When BPHC collects confidential health information directly from a client, he/she shall be informed, upon request and if permitted by applicable law, of its existence, use, and disclosure and shall be given access to the information.

H. **Security.** BPHC shall establish and require from staff members a high level of physical and electronic security for client confidential health information.

#### SCOPE

This Policy applies to all BPHC employees, contract employees, consultants, agents, business associates, and temporary employees (including interns and volunteers). For the purposes of this Policy, all such individuals shall hereafter collectively be referred to as "BPHC staff." All BPHC staff that has access to confidential health information must adhere to this Policy. This Policy may be revised from time to time as necessary to comply with applicable state and federal law or to implement BPHC policy.

#### DEFINITIONS

For the purposes of this Policy, the following words and phrases shall have the following meanings:

**"Access"** means the provision by BPHC to an individual of an opportunity to inspect or review confidential health information about that individual held by BPHC.

**"Aggregate Data"** means data collected from individual-level records that have been combined for statistical or analytical purposes and that are maintained in a form that does not permit the identification of individuals.

**"Authorization"** means a written voluntary agreement by client or legal representative, consenting to the use, or disclosure of confidential health information.

**"Business Associate"** means a person who:

on behalf of BPHC, but other than an employee of BPHC, performs, or assists in the performance of a function or activity involving the use or disclosure of confidential health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or provides legal, actuarial, accounting, consulting, data

aggregation, management, administrative, accreditation, or financial services to or for BPHC, other than an employee of BPHC, where the provision of the service involves the disclosure of confidential health information from BPHC, to the person or organization in the Business Associate role.

**“Client”** means the individual about whom the data or health information relates.

**“Confidential health Information”** means any individually identifiable information, including, but not limited to, medical and demographic information, that:

Reveals the identity of the client or is readily identified with the client, such as, but not limited to, name, address, telephone number, social security number, health identification number, or date of birth; or provides a reasonable basis to believe that the information could be used, either alone or in combination with other information, to identify a client; and includes any protected health information, as defined by this Policy.

**“Confidentiality”** means BPHC’s obligation to protect the health information with which it has been entrusted.

**“Contact”** means to communicate or attempt to communicate with a client or the client’s parent, guardian, or health care provider by any means, including, but not limited to, in-person, telephone, facsimile, letter, or electronic mail.

**“Data Linkage”** means a method of assembling data contained in two or more different files or records to relate significant health and other events for the same individual, organization, community, or other unit of analysis.

**“De-Identified Data”** means data or information that has been subject to methods for rendering information not individually identifiable, such as removal of personal identifiers including name, address, telephone number, social security number, health identification number, or date of birth.

**“Disclose”** means to transfer, disseminate, release, or otherwise communicate or divulge any confidential health information to any person or entity outside BPHC.

**“Health Information”** means any information, whether oral or recorded in any form or medium, that: is created or received by BPHC; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

**“Individual-Level Data”** means any data or information collected and maintained concerning a specific individual.

**“Individually Identifiable Health Information”** means information that is a subset of health information, including demographic information collected from an individual, and:

is created or received by BPHC; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

**“Institutional Review Board”** means any board, committee, or other group formally designated by an institution, and approved by the federal Health and Human Services pursuant to 45 CFR Part 46 to review, approve, and periodically evaluate research projects to protect the rights of human research subjects.

**“Personal Data”** means any information concerning an individual who, because of name, identifying number, mark or description can be readily associated with a particular individual, provided that such information is not contained in a public record.

**“Pledge of Confidentiality”** means a written statement, dated and signed by an individual who is granted access to confidential health information, that certifies the individual’s agreement to abide by the confidentiality restrictions stated in the written statement.

**“Privacy”** means the right of an individual to control the circulation of data or information about himself or herself, freedom from unreasonable interference in an individual’s private life, and an individual’s right to protection against misuse or unjustified publication of his or her personal data or information.

**“Protected Health Information”** means individually identifiable health information that is: 1. transmitted by electronic media; 2. maintained in any medium described in the definition of electronic media in the Privacy Regulation, or 3. is transmitted or maintained in any other form or medium. Confidential Health Information includes Protected Health Information.

**“Public Health Authority”** means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors of persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

**“Public Health Purpose”** means a population-based activity or individual effort primarily aimed at: the reduction of morbidity or mortality; the prevention of injury, illness, disease, disability or premature mortality; the improvement of health outcomes; or the promotion of health in the community, including assessing the health needs and status of the community through public health reporting and surveillance, developing public health policy, and responding to public health needs and emergencies.

**“Research”** means a systematic investigation designed primarily to develop or contribute to general knowledge, including public health, medical, social, demographic, and historical research.

**“Security”** means the manner of assessing the threats and risks posed to confidential health information data and taking the appropriate steps to protect that data against unintended or unauthorized access, use, intrusion, disclosure or such other dangers as accidental loss or destruction.

**“Use”** means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information by BPHC.

## GENERAL PRIVACY POLICY

All BPHC staff shall comply with the following policy on use and disclosure of confidential health information.

### **A. COMPULSORY LEGAL PROCESS**

1. Except for requests by the client or the legally authorized representative of the client, any BPHC staff that receives a request for access to confidential health information in BPHC’s possession or receives a subpoena, discovery request, court order or any other form of compulsory legal process to provide such confidential health information shall immediately notify the Office of the General Counsel.

2. BPHC staff shall not disclose any confidential health information unless and until authorized to do so by the Office of the General Counsel.

**B. LIMITING COLLECTION OF CONFIDENTIAL HEALTH INFORMATION**

1. BPHC staff shall collect no more confidential health information than is necessary for the stated purpose.
2. BPHC staff shall collect confidential health information only when such collection is:
  - a. authorized by law or regulation;
  - b. or when confidential health information is deemed necessary to further a public health purpose.

**C. LIMITING ACCESS TO CONFIDENTIAL HEALTH INFORMATION**

1. Access shall be limited to the minimum number of individuals who are reasonably necessary to conduct the public health purpose.
2. BPHC staff shall limit access to confidential health information to only those staff that have a legitimate need to access the information in order to conduct the public health purpose.

**D. LIMITING USE OF CONFIDENTIAL HEALTH INFORMATION**

1. BPHC staff shall limit use of confidential health information to those purposes for which the information was collected or other public health purposes permitted by law which further the mission of BPHC.
2. Whenever identifiable information is not necessary to conduct the public health purpose, the confidential health information shall be de-identified.

**E. LIMITING DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION**

1. BPHC staff shall limit disclosure of confidential health information to only authorized persons.
2. Authorized persons include:
  - a. the client;
  - b. any other person authorized by the client pursuant to a written authorization;
  - c. BPHC staff that need access for a public health purpose related to public health surveillance or investigation;
  - d. law enforcement officers or other persons pursuant to law or court order when approved by the Office of the General Counsel; or
  - e. to any other person authorized by law to receive such information when approved by the Office of the General Counsel.
3. BPHC staff shall limit disclosure of confidential Health Information to the minimum necessary amount of confidential health information that is required to accomplish the intended purpose of the use or disclosure.

**F. AGREEMENT TO MAINTAIN CONFIDENTIALITY**

1. All BPHC staff shall strictly maintain the confidentiality of all individually identifiable health information held by BPHC.
2. No person having access to confidential health information shall disclose, in any manner, any confidential health information except as necessary for conducting a legitimate public health purpose, as defined in this Policy, or when authorized by law.

3. All BPHC staff will receive education and training regarding the confidentiality and security principles addressed in this Policy and the specific procedures developed and implemented pursuant to this Policy.
4. In addition, all new employees, at the time of hire, and current BPHC staff shall sign a Pledge of Confidentiality for Employees. (Form A)
5. Independent contractors, volunteers, and interns who have access to client confidential information shall enter into a written agreement agreeing to abide by this Policy.
6. BPHC staff shall agree to maintain the confidentiality of client confidential health information even after termination of employment or other contractual obligations.
7. Each supervisor shall insure that all current BPHC Staff and new employees receive a copy this Policy.
8. Copies of signed confidentiality pledges shall be maintained by the Human Resource Department for all BPHC staff.
9. Independent Consultant and Contractors of BPHC that will have access to confidential health information must sign a Business Associate Agreement. (Form B)

#### G. OPENNESS

1. BPHC is committed to giving individuals notice about how it collects, uses, and discloses confidential health information.
2. BPHC's Notice of Privacy Practice will be available upon request by making a written request to the Privacy Officer, Boston Public Health Commission, 1010 Massachusetts Ave., Boston, MA 02118, or visiting BPHC web site at <http://www.bphc.org>. This Notice of Privacy Practice is subject to change by BPHC. (Form C)

#### H. INDIVIDUAL ACCESS

1. When BPHC collects confidential health information directly from the client, he/she shall be informed, if permitted by applicable law, of its existence, use, and disclosure, and the client shall be given access to the information.
2. Clients may request permission to access and/or copy confidential health information about themselves in the possession of BPHC in accordance with section VII. of this Policy.
3. BPHC staff shall take reasonable measures to verify the identity of the client prior to the disclosure of the information.
4. Any confidential health information about a person other than the client shall be redacted before disclosure of confidential health information to the client.
5. A Client shall be permitted to inquire about the accuracy and completeness of confidential health information held by BPHC and to have the confidential health information amended if appropriate as set forth in section VII of this Policy.
6. BPHC may refuse to disclose information if the disclosure, as determined in writing by a licensed health care provider or the Office of the General Counsel, could reasonably be expected to:
  - a. result in immediate and grave harm to the individual's safety;
  - b. the information contains references to other individuals;
  - c. the disclosure could reasonably be expected to harm public health or safety; or

- d. Massachusetts or federal law prevents BPHC from disclosure of the information.
7. A client shall be permitted to request in writing to receive confidential communications from BPHC if the client states that routine methods of communication would endanger the client.
8. A client shall be permitted to receive an accounting of disclosures of his/her confidential health information unless the disclosure is related to treatment, payment, health care operation or pursuant to a valid authorization.

#### I. SECURITY

1. BPHC staff that have access to confidential health information shall ensure that such information is maintained in a secure manner which prevents unauthorized individuals from gaining access to such information.
2. Confidential health information maintained in an electronic format shall be stored on a password-protected and secure computer system.
3. Confidential health information shall not be left in plain view or otherwise accessible on a computer screen or in a work area when the authorized user is not present.
4. Confidential health information shall not be transmitted by email.
5. All confidential health information maintained in paper format shall be stored in locked file cabinets or other appropriate storage method which prevents unauthorized access as determined and approved by the Operations Department.
6. BPHC staff shall not attempt to exceed the scope of their authorized access to client confidential health information or attempt to circumvent any BPHC systems security measures designed to prohibit unauthorized access to client confidential health information.

#### J. DATA INTEGRITY

1. Every effort shall be made by BPHC staff to ensure the quality, accuracy, and reliability of the data and records under its control, whether contained in written, electronic, or other format.
2. BPHC staff will only collect confidential health information that is relevant to the purposes for which it is to be used, and will use reasonable efforts to ensure that such data is accurate, complete, and timely.
3. BPHC staff must ensure that confidential health information is protected from unauthorized modification and destruction.
4. BPHC staff shall strive to maintain the accuracy of the confidential health information held, including allowing individuals to have the opportunity to review and amend their confidential health information as set forth in section VII.

#### K. NON-COMPLIANCE

1. All BPHC staff is required to comply with this Policy. Any BPHC staff member who fails to comply with this Policy may be denied further access to confidential health information and may be subject to disciplinary action up to and including termination of employment.
2. BPHC staff shall immediately report to his/her supervisor any violations of this Policy.
3. BPHC staff members are protected from retaliation for reporting violations of this Policy by Massachusetts law (M.G.L. c. 149, §185).

4. BPHC may audit the use and disclosure of confidential health information by BPHC staff in order to ensure compliance with this Policy.

L. **CONFIDENTIALITY PROCEDURES**

1. Each BPHC Department/Program shall implement the specific procedures, guidelines and utilized the forms adopted with this Policy.
2. A BPHC Department/Program may adopt additional procedures, practices or forms which specifically address the operations of the Department/Program provided that the procedures, practices, or forms are consistent with this Policy and have been approved by the Office of the General Counsel.
3. BPHC staff shall comply with all procedures and practices adopted pursuant to this Policy.

M. **RESEARCH STUDIES**

1. *Approval of Research Project Using Confidential Health Information*

- a. BPHC staff that are conducting a research project which requires access to confidential health information held by BPHC shall consult with the Director of the Research Office to ensure that appropriate research protocols are followed.
- b. BPHC staff that are conducting a research study or other public health investigation which involves contact with clients shall consult the Director of the Research Office for approval of the contact protocol (e.g., consent, authorization forms, questionnaires, interview scripts).

2. **Data Linkage**

- a. If confidential health information is used for data linkage, the linked data set shall be stripped of personal identifiers and all identifiers shall be destroyed unless there is a legitimate public health purpose for retaining such identifiers.
- b. BPHC staff shall conduct data linkage projects in-house whenever possible and disclose only the linked data set without personal identifiers, other than a unique identification number, unless otherwise approved in writing by the Director of the Research Office.

3. **Data Destruction for Research Purposes**

- a. As soon as reasonably practicable, BPHC staff shall de-identify confidential health information and destroy all identifiable information used for research purposes unless there is a legitimate public health purpose for retaining such identifiable information or retention of the information is required by law.

4. **Publications and Reports**

- a. All reports and publications based on confidential health information shall contain only aggregate data and no personally identifiable information or information which could lead to the identification of an individual.
- b. A client's personal identifiable health information shall not be published or disclosed by BPHC without proper written authorization from the client which specifically grants BPHC the authority to use her/his confidential health information for such reports and publications.
- c. All aggregate data presented in such reports or publications shall comply with BPHC guidelines on cell size suppression as determined by the Director of the

Research Office to ensure that individuals cannot be identified based on the data presented.

- d. No maps based on confidential health information may be published or disclosed with sufficient detail so as to allow for identification of individuals.

## PROCEDURE, PRACTICE & GUIDELINES

### A. COLLECTING AND DISCLOSING CONFIDENTIAL HEALTH INFORMATION

#### 1. Mail

- a. BPHC staff shall take reasonable measures to ensure that confidential health information being submitted to BPHC by mail or courier service is properly addressed by the sender.
- b. If any Department/Program receives mail with confidential health information which was intended for a different Department/Program, a staff member must bring the mail to the appropriate Department/Program or seal it in another envelope marked "Confidential" and send it via inter-office mail to the intended recipient or appropriate program.
- c. All outgoing mail containing confidential health information must have a return address (with room number, where appropriate) and shall be stamped "Confidential." All reasonable efforts shall be made to ensure that the addressee information is complete and correct.
- d. All confidential health information shall be sent in a sealed envelopes which complete conceals the content of the envelope.
- e. Confidential health information should be sent by registered or certified mail or other delivery service that allows for tracking delivery and receipt of documents whenever feasible.

#### 2. E-Mail or Other Electronic Transmission

Confidential health information shall not be transmitted by e-mail. Any other electronic transmission of confidential health information shall be in accordance with BPHC policies related to the electronic transmission of information.

#### 3. Fax

- a. BPHC staff shall make reasonable efforts to ensure that all faxes containing confidential health information are sent to secure areas.
  - i. Secure areas are those areas in which only individuals that have a need to know confidential health information have access
  - ii. Contact the Operations department for guidance and/or question regarding a secure location for fax machines
- b. When sending a fax containing confidential health information, BPHC staff should call the intended recipient of confidential health information to confirm the correct fax number and ensure that the intended recipient is waiting for the transmission, or that measures are in place to ensure confidentiality of the confidential health information.
- c. A cover sheet that contains a confidentiality disclaimer must accompany all faxed documents containing confidential health information. The following language

must be included in all fax coversheets used to fax confidential health information.

“These transmitted documents contain confidential information and are intended solely for use by the individual named above as the recipient. If you are not the intended recipient or such recipient’s employee or agent, be aware that any disclosure, copying, distribution, or use of the contents of this transmission is prohibited. If you have received this transmission in error, please notify the sender by telephone immediately so that we may arrange to retrieve this transmission at no cost to you.”

4. Hand Delivery

- a. All confidential health information must be kept under protective cover, in a sealed envelope or locked briefcase, when being transported or delivered by hand.
- b. Hand delivery shall be to the intended recipient or the intended recipient’s authorized agent only.
- c. Government or BPHC issued photo identification is required for all in-person releases of confidential health information unless the identity of the recipient is known.

5. Telephone

- a. Confidential health information shall not be transmitted by telephone communication unless the intended recipient is known to the caller or the intended recipient’s identity can be reasonably verified.
- b. The identity and authority of unknown persons requesting confidential health information must be verified before confidential health information is released by telephone.
- c. In the case of a health care provider, verification may be made by obtaining the caller’s name and phone number and returning his/her call to confirm identity before such information is released.
- d. Confidential health information containing personal identifiers (e.g., names, Social Security numbers, medical record numbers, etc.) shall not be left on any voice-mail system or with a receptionist.
- e. Use of a cellular phone or public telephone to communicate confidential health information should be avoided to the greatest extent possible.
- f. All telephone calls in which confidential health information is discussed must be made, to the greatest extent possible, in a secure area which limits the unauthorized disclosure of client confidential health information.
- g. No confidential health information shall ever be sent via a pager.
- h. Confidential health information shall not be discussed in public areas, such as, but not limited to, lobbies, elevators, and cafeterias.

B. **USE OF CONFIDENTIAL HEALTH INFORMATION**

1. Use Within the Department/Program

- a. A Department/Program that possesses confidential health information shall use that information only for:
    - i. The specific purpose(s) for which it was collected, which includes treatment, payment, quality assurance;
    - ii. BPHC approved research as set forth in section V of this Policy,
    - iii. when required by law or
    - iv. as authorized by the client.
    - v. access to confidential health information shall be limited to only those persons within the Department/Program that have a “need-to-know”.
2. Use Within BPHC
- a. confidential health information held by one Department/Program shall not be shared with any other Department/Program unless authorized by the Privacy Officer, required by law when approved by the Office of the General Counsel, or authorized by the client.
3. Access Rights
- a. Every BPHC staff member, including interns, volunteers and temporary employees who will be granted access to confidential health information, must sign a Pledge of Confidentiality for Employees, Contract Employees and Interns. (Form A)
  - b. Independent Contractors and agents of BPHC that will have access to confidential health information must sign a Business Associate Agreement with BPHC **prior** to receiving access to confidential health information.
  - c. each Department/Program shall identify in writing a list of those staff members within the Department/Program by name or job description and shall determine the level of access to confidential health information that each BPHC staff member shall have to perform his/her duties.
    - i. The list must be updated as necessary to keep it current and a copy of the list shall be given to BPHC’s Privacy Officer.
    - ii. The list shall contain the level of access each employee has to paper files, databases, and secure areas where confidential health information is kept.
    - iii. A copy of this list shall be provided to the Director of Information Services and Manager of IT Users to ensure coordinate authorized access control to electronic databases.
  - d. Temporary employees, interns, and volunteers shall not be granted access to confidential health information, unless first authorized by the supervisor in charge of such individuals of written approval by the Department /Program Director.

**C. DESIGNATED RECORD SET, STORAGE, MAINTENANCE AND DESTRUCTION OF CONFIDENTIAL HEALTH INFORMATION**

- 1. Designated Records Set . Pursuant to this Policy, a client’s right to request access, an amendment, place restriction on access and/or request copies of his/her personal health information is limited to that health information that is maintained in Designated Record Sets, as determined by each Program.

- a. Evaluation of Documentation
- i. Each Program/Department must evaluate client files and determine which documents contain individually identifiable confidential health information about the client. A written policy must be developed and implemented at the program level to evaluate the documentation maintained by each program to determine those groups of confidential health records that should be categorized as Designated Record Sets.
  - ii. The written policy should ensure that the following information is gathered about the evaluated records:
    1. Documentation type (e.g., paper medical record, Sophia database)
    2. Basic content (e.g., assessments, reports,, examinations)
    3. Location of the documentation (e.g., School Based Health Clinic)
    4. Contact person (e.g., caseworker)
  - iii. Documentation must be maintained that supports the Programs' assessment of its records which were reviewed in making the determination of its Designated Record Sets. Documentation may be maintained electronically or on paper.
  - iv. Selected records which are determined to constitute the Designated Record Set shall be separate from other client information. The Designated Record Set must be kept current and available for reference should a client request access to his/her health information, including comments that identify any information included in a Designated Record Set that the client would not have a right of access, amendment, or copies.
  - v. Records contained in the Designated Record Set must be maintained for a period of at least six years.
- b. Inclusions Confidential health information in all types of media (e.g., paper, oral, video, electronic, film, digital) must be considered when determining what documents shall be included in the Designated Record Set. Minimally, the following categories of records should be considered Designated Record Sets:
- i. Eligibility information maintained by health plans;
  - ii. Enrollment records maintained by health plans;
  - iii. Claims records submitted to or received from health plans;
  - iv. Remittance Advices and records of payments;
  - v. Client Statements related to health condition;
  - vi. Claims adjudication records;
  - vii. Case or medical management records maintained by health plans; and
  - viii. Other records used by BPHC to make health related decisions about individuals.
  - ix. Records created and/or maintained by a Business Associate for services rendered to a BPHC program must be considered when evaluating documentation for Designated Record Sets.

- x. Confidential health information specifically created and/or maintained by Business Associates, when acting on behalf of a BPHC Program, is subject to the client rights provisions as set forth in section VII. to request access to or amendment of such information in accordance with the Business Associate Agreement.
  - c. Exclusions Confidential health information that will not be used to make decisions about treatment of a client should not be included in a Designated Record Set. Such information may be found in many types of records that include significant information not relevant to the client, as well as information about other persons.
- 2. Method of Storage for Paper Copies
  - a. All confidential health information shall be stored in locked areas that do not allow public access, including but not limited to, secured file cabinets.
  - b. When the Operations Department deems it feasible, a security measure including but not limited to pass code should be installed in areas where confidential health information is kept.
  - c. Operations shall document all security measures used by BPHC Programs/Department, their locations and who has access and/or who has authority to grant access to such secure area.
  - d. To protect confidential health information, BPHC staff shall not leave confidential health information on a desk or work area when he/she is away from the desk/office, unless the area is secured from unauthorized access. (e.g., locked door).
  - e. BPHC staff shall not take confidential health information from a assigned secured area unless it is required for a field visit, meeting, or when otherwise necessary for work r elated purposes.
- 3. Storage for Electronic Copies of Confidential Health Information
  - a. Confidential health information stored in a computer system shall be stored in a secure manner.
  - b. Access rights to stored confidential health information shall be limited to individuals who need the information to perform their job and are limited to only that information necessary to perform their job.
  - c. No BPHC staff member shall share her/his passwords with anyone other than Department/Program directors, or the Director of the IT department.
  - d. The IT, IS and Operations department must be immediately notified when BPHC staff are transferred, resign or are terminated. Transferees may need different access rights at their new job.
    - i. Upon termination, or resignation of a BPHC staff member's employment with BPHC, all access rights shall be promptly removed, especially if they have dial-in access.
    - ii. Program/Department management, Human Resources, Operations and IT Services staff shall coordinate the date and time of the termination of the staff member's employment so that computer network access and other access to confidential health information are terminated in a timely manner.

- e. To prevent BPHC staff from inadvertently displaying confidential health information when away from their workstation, computers providing access to confidential health information shall have screen saver or a desktop log-off that is automatically activated.
  - f. If confidential health information is on a stand-alone computer and not on the network, then the stand-alone computer must be in a secured area and the confidential health information must be password protected.
4. Maintenance
- a. Policies and procedures adopted in this Policy and program policies created in accordance with this Policy to protect Confidential health information which is collected, used, and stored by the program shall be enforced within each Program/Department by a data custodian appointed by the Department/Program Director and approved by the Privacy Officer.
  - b. Such data custodian shall implement this Policy and other reasonable measures which are in accordance with this Policy to protect the integrity of the information.
5. Destruction
- a. Confidential health information that is no longer needed should be destroyed whenever possible, or archived, consistent with BPHC's record retention policies whichever is later. The Director of Operations shall provide each Department/Program Director with a copy of BPHC's record retention policy.
  - b. Upon written approval by Operations and the Privacy Officer, each program should have access to a shredder to use for disposal of all records with personal identifiers.
  - c. Any materials containing confidential health information that is not required to be retained (See BPHC Retention Policy) must be shredded as soon as they are no longer needed.
  - d. Confidential health information stored on electronic media (e.g., disk, CD, etc.) shall be completely erased or destroyed before disposal of the electronic media.

#### D. PROCEDURES FOR RELEASE/DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

1. When Confidential Health Information May Be Disclosed
- a. Confidential health information may not be disclosed to non-staff members, agents or business associates of BPHC without the written authorization of the client, except for the following purposes:
    - i. The disclosure is authorized by law or regulation and the Office of the General Counsel has approved such disclosure.
    - ii. The disclosure is required by judicial order or other legal process, and the disclosure is approved by the Office of the General Counsel. A subpoena does not mean automatic release of confidential health information. When BPHC staff person receives a subpoena potentially related to the release of confidential health information, he or she must immediately notify his/her supervisor and the Office of the General Counsel.
    - iii. The disclosure is authorized by BPHC for research which has been approved in writing by the Director of the Research Office /or a member

of the Executive Administration department. A Pledge of Confidentiality must be signed and returned to BPHC by all researchers who will have access to the data before confidential health information is disclosed.

- iv. The disclosure is required for coordination of benefits or for treatment, payment or health care operations consistent with the requirements of HIPAA.
2. To Whom Confidential Health Information May Be Disclosed
    - a. Confidential health information may be disclosed under the circumstances listed above to the appropriate individual authorized to receive the information for the specified purpose.
    - b. Each Department/Program must develop and maintain a list which specifies to whom it releases confidential health information on a routine basis and a specific contact person to whom information is disseminated. The list should be updated as necessary and a copy of this list shall be given to BPHC's Privacy Officer.
  3. Accounting of Disclosures
    - a. Each Department/Program must maintain a log of disclosures of confidential health information with relevant information including, at a minimum:
      - i. the date of the disclosure;
      - ii. to whom, by whom, and the information provided;
      - iii. A brief description of the information disclose; and
      - iv. Purpose or basis for disclosure.
    - b. These logs must be maintained in a secure manner and retained for a period no less than six years or in accordance with BPHC retention policy whichever is later.
  4. Disclosure Procedures
    - a. Requests for disclosure of confidential health information should be in writing unless necessary for the urgent care of an individual which makes a written request unfeasible.
    - b. Each Department/Program should utilize the authorization form issued pursuant to this Policy (Form I) to document all requests for disclosure of confidential health information.
    - c. Disclosure of confidential health information should be by mail or in-person delivery, whenever feasible. Disclosure shall not be made by telephone unless necessary for the urgent care of an individual.
  5. Verification of Authorized. Recipient Reasonable measures must be taken to verify the identity of the client or the individual authorized by the client to receive confidential health information.
    - a. When the request is made by a client, the client must present government issued photo identification before disclosing confidential health information.
    - b. When the request for disclosure is made by a representative/agent of the client, no disclosure shall be made without a written authorization which specifies to whom the confidential information can be disclosed and what information shall be disclosed along with government issued photo identification.

## CLIENT RIGHTS AND THE COMPLAINT PROCESS

### **A. CLIENT RIGHTS**

1. This Policy, in accordance with the HIPAA Privacy Rule, requires that BPHC staff providing direct and indirect health care shall provide the client, upon first contact, with a copy of BPHC's Notice of Privacy, (Form C) and/or inform the Client where the Notice of Privacy is located in the facility
  - a. After providing the client with a copy of BPHC's Notice of Privacy, BPHC staff shall obtain the client's written acknowledgement of receipt or opportunity to receive BPHC's Notice of Privacy Practice using the coversheet of Form D of this Policy.
  - b. The executed Notice of Privacy Practices Acknowledgment Form shall be placed in the client's designated health records for a period of no less than six years or in accordance with BPHC's retention policy, whichever is later.
2. BPHC staff shall provide clients upon written request, reasonable access to designated records sets containing confidential health information about the client, to request an amendment to the designated record set and an accounting of the disclosure or his/her confidential health information not related to treatment, payment, health operations, or pursuant to a client's authorization.
3. BPHC staff shall provide a client, upon request, the proper Form as set forth in Section IX of this policy, to request access, to request an amendment, to request a limitation to the disclosure or an accounting of disclosure of disclosure of his/her confidential health information.
4. All privacy request for access, request to amend, request to restrict disclosure and/or request for an accounting of disclosures must be documented and given the staff member's immediate supervisor.
5. BPHC shall not amend, at a client's request, any information in a record that the Program/Department knows to be true and accurate.
6. The supervisor shall forward the client's request(s) for amending, placing restrictions and an accounting of disclosure of their confidential health information to the Privacy Officer and/or his/her designee(s) within the Department.
7. The Privacy Officer shall ensure that all client requests related to this Policy are recorded accurately, and are retained for a period of at least six years from either the date of creation or the date when it was last in effect, whichever is later.
8. The Privacy Officer shall consult with a license health care provider and/or the Office of the General Counsel when necessary to determine whether to grant or deny the client's rights as set forth in Article VII, Section A2 of this Policy.

### **B. COMPLAINT PROCEDURE**

1. When a BPHC staff member receives a complaint from a client and/ or wishes to file a complaint regarding a violation of this Policy, the staff member shall report the complaint immediately to his/her supervisor who shall report the alleged violation to the Privacy Officer or his/her designee within the Department.

2. The Privacy Officer and/or his/her designees shall respond immediately to privacy complaints that are general in nature and do not require additional research or privacy expertise.
3. The Privacy Officer shall document all the facts provided by an individual and the resolution, if any, in their information referral system.
4. The Privacy Officer shall forward all privacy complaints that require additional research to the Office of the General Counsel for resolution.
5. The documentation of all privacy complaints and the resolutions of such complaint shall be maintained by the Privacy Officer for a period of at least six years from either the date of creation or the date when it was last in effect, whichever is later, and shall contain no individually identifiable health information other than that provided by the individual.
6. The Privacy Officer shall provide reports about privacy complaints to the Director of Administration each quarter and as requested by the Director of Administration.
7. Such report information will be used for evaluation and process and/or procedure enhancement, as appropriate.

**C. IMPLEMENTATION**

The Privacy Officer shall use designated a staff member within each Department that create, use or disclose protected health information to document the receipt and disposition of all written request for access, amendments to his/her designated record set and complaints alleging a violation of this Policy

**CONTACT INFORMATION**

Any questions concerning this Policy and/or Procedures should be directed to the Office of the General Counsel, in writing at:

Boston Public Health Commission  
Office of the General Counsel  
1010 Massachusetts Ave., 6<sup>th</sup> Fl.  
Boston, MA 02118



## APPENDIX D: Service Zone Agreements

### **SERVICE ZONE AGREEMENT Template**

AGREEMENT dated as of DATE, by and between Boston Emergency Medical Services (Boston EMS), a bureau of the Boston Public Health Commission and \*NAME.

WHEREAS, Boston EMS is the designated primary ambulance service (as that term is used in 105 CMR 170.000, as amended from time to time (the “OEMS Regulation”) for the City of Boston, Massachusetts (the “Municipality”);

WHEREAS, \*NAME has a mutual aid agreement with Boston EMS or has notified the municipality through Boston EMS, in accordance with 105 CMR 170.248, that it holds contracts for primary ambulance response (as defined in the OEMS Regulations) with facilities located within the geographic boundaries of the City of Boston (the “Contracted Facilities”), and the Contracted Facilities are listed on Exhibit A hereto;

WHEREAS, Boston EMS and \*NAME desire to cooperate in the coordination of dispatch and response of ambulance and First Responder resources in accordance with the OEMS Regulations and the Service Zone Plan adopted pursuant thereto;

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree to the following:

1. \*NAME shall provide primary ambulance response to its Contracted Facilities
2. In the event that \*NAME determines that, with respect to a request for primary ambulance response from a Contracted Facility, it cannot satisfy the applicable response time standard contained in the Municipality’s Service Zone Plan, it will notify Boston EMS.
3. Notification of Boston EMS for Unusual Occurrence. An EMS service operating within the Service Zone pursuant to a provider contract or agreement to provide back-up services shall notify Boston EMS Dispatch Operations whenever one of the following situations exists. This list is not meant to be all-inclusive, but rather is a general guideline for incidents warranting Boston EMS notification.
  - a. Homicide, suicide, hostage situation, or other suspicious or unusual incident;
  - b. Question of child abuse or elderly abuse;
  - c. The threat of harm to an EMT on scene; a violent patient or patient requiring restraint
  - d. An incident requiring a prolonged time on scene (e.g., entrapment, fire, etc.)
  - e. Question of a hazardous material incident; explosive or other incendiary device.
  - f. An EMS Vehicle crash, or theft of an EMS vehicle or equipment while operating in the City of Boston service zone.

- g. Death or serious injury to an on-duty member of a public safety agency or private ambulance service.
  - h. Any serious burn; gunshot wound, stabbing, or other incident likely to require a Boston Police and/or Boston Fire Department investigation
  - i. Any potential mass casualty incident or incident requiring a building evacuation (power failure, loss of heat, etc.)
  - j. Any other significant or high profile incident involving an EMS unit within the City of Boston where a Boston EMS Supervisor and/or Command Staff response may be warranted; or any requests from the media for information regarding an EMS related incident within the Boston service zone.
4. Any dispute between EMS personnel operating within the Service Zone and members of other public agencies concerning patient care, scene management, or general conduct shall be referred to a Boston EMS Field Supervisor immediately. The Field Supervisor shall obtain the relevant facts from the involved personnel of both agencies, attempt to resolve the dispute, and submit a written report to the BEMS Shift Commander before the end of the work shift.
5. EMS Services shall not engage in any advertising that is deceptive or misleading to the public or for services other than those for which it is currently licensed, for which its EMS personnel and EMS Vehicles are certified and for which it is placed in services. EMS Personnel operating in the service zone pursuant to a provider contract or agreement to provide back-up services shall not hold themselves out to the public or other public safety agencies as being a member of "Boston EMS", nor shall they use markings on uniforms, facilities, or vehicles which could reasonably lead a member of the public to believe the individual is a Boston EMS employee, or the vehicle is owned / operated by Boston EMS.
6. Boston EMS shall be notified whenever an EMS Service operating in the Boston service zone pursuant to a provider contract or agreement to provide back-up services is granted a special project waiver by the Department of Public Health, Office of Emergency Medical Services.
7. \*NAME agrees to provide upon request from Boston EMS a summary of primary ambulance responses within the City of Boston Service zone, including incident location, nature of the medical emergency, response time information, and call disposition for the purposes of monitoring compliance with the service zone plan.
8. Whenever, by the terms of this Agreement, notice is to be given by one of the parties to the other, such notice shall be in writing and shall be deemed to be received by the intended recipient (i) when delivered personally, (ii) the day following delivery to a nationally recognized overnight courier service with proof of delivery, or (iii) three (3) days after mailing by certified mail, postage prepaid with return receipt requested, in each case addressed to the parties at the addresses set forth as follows or such other address or addresses as may from time to time hereafter be designated by the parties, respectively, by like notices. The addresses referenced above are as follows:

Primary Ambulance Service: **Boston EMS**  
**767 Albany Street**  
**Boston, MA 02118**  
Attn: Chief of Department

CC: Boston Public Health Commission  
Office of the General Counsel  
1010 Massachusetts Ave., 6<sup>th</sup> Fl.  
Boston, MA 02118

Contracted Ambulance Service: \*NAME Ambulance Service

Attn:

CC: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Waiver. The failure to insist upon strict compliance with any of the terms, covenants or conditions contained herein shall not be deemed a waiver of such terms, covenants and conditions, nor shall any waiver or relinquishment of any right at any one or more times be deemed a waiver or relinquishment of such right at any other time or times.

10. Governing Law. The parties agree that this Agreement shall be governed, construed and enforced in accordance with the laws of the Commonwealth of Massachusetts to the fullest extent permitted by law, without regard to the application of conflict of laws rules. If any portion or provision hereof shall to any extent be invalid or unenforceable, the remainder of this Agreement, or the application of such portion or provisions in circumstances other than those in which it is held invalid or unenforceable, shall not be affected thereby, and each portion or provision of this Agreement shall be valid and enforced to the fullest extent permitted by law.

11. Records. \*NAME shall maintain books, records, and other compilations of data relative to the services to be performed hereunder and all such records shall be retained for at least six years. Boston EMS shall have the right to examine and copy such records upon reasonable notice and at such times and expense as may be reasonable.

12. Independent Contractor. \*NAME is retained solely for the purposes of and to the extent set forth in this Contract. \*NAME relationship to the Boston EMS during the term of this Contract shall be that of an independent contractor. \*NAME shall have no capacity to involve the BPHC as its agent in any contract or to incur any liability on the part of the Boston EMS. \*NAME, its agents or employees shall not be considered as having the status or pension rights of an employee, provided that \*NAME shall be considered an employee for the purpose of M.G.L. c. 268A (the Conflict of Interest Law).

13. Insurance. \*NAME shall maintain at a minimum Public Liability, Property Damage, Employers' Liability, Worker's Compensation and Motor Vehicle Liability (personal Injury and Property Damage) and such other liability insurance coverage as may be required hereunder sufficient to protect \*NAME and Boston EMS from any risks or claims which may be associated

with this Contract and as are customary in the Contractor's business and shall provide the Boston EMS with evidence of such coverage. In the event any changes occur in such liability coverage during the period of performance, the Contractor shall notify Boston EMS of such changes and shall provide the Boston EMS with new evidence of coverage.

14. Merger. This instrument contains the entire agreement between the parties in respect to its subject matter and supersedes any agreements or arrangements made prior to the date hereof.

15. Successors. This Agreement shall be binding upon and shall inure to the benefit of the parties, their respective successors and assigns.

IN WITNESS WHEREOF, and intending to be legally bound, the duly authorized officers of the parties hereto affix their signatures below and execute this Agreement under seal as of the date first set forth above in this Agreement.

PRIMARY AMBULANCE SERVICE:

By: \_\_\_\_\_  
Name  
Executive Director, Boston Public Health Commission  
Hereunto Duly Authorized

CONTRACTED AMBULANCE SERVICE:

By: \_\_\_\_\_  
Name:  
Title:  
Hereunto Duly Authorized