Testimony to the Senate Committee on Utilities
In Support of SB379

By Sheriff Jacob O. Welsh
January 29, 2026

Chair and Members of the Kansas Senate Committee on Utilities,

Thank you for the opportunity to speak today regarding Senate Bill 379. I am speaking as the Sheriff of Chase County, as a representative of the Kansas Sheriffs' Association, and on behalf of the many small, one-seat Public Safety Answering Points (PSAPs) across Kansas whose voices are too often underrepresented in statewide conversations—but whose operational realities must be central to responsible policy.

I want to begin by commending Chair Ed Klumpp and the SB 11 Exploratory Committee for the quality of their work and for focusing on practical solutions that save lives and fit Kansas PSAP operations. Kansas is already a national leader in 911 technology, and this plan builds on that foundation by expanding access to medical guidance—first through Telecommunicator CPR (T-CPR) and then, as capacity allows, through Emergency Medical Dispatch (EMD)—without compromising local control or system stability.

I also want to acknowledge the American Heart Association. We share AHA's mission to save lives from sudden cardiac arrest. Their advocacy has elevated public awareness and trained more Kansans in CPR—work I deeply respect. Where we differ is not on the goal, but on how Kansas reaches it safely and sustainably for all PSAPs, especially the smallest.

This is not a debate about theory—it is a question of operational reality and safety. In one-seat PSAPs, the single telecommunicator is simultaneously answering 911, dispatching EMS, fire, and law enforcement, monitoring the jail, handling walk-ins, and documenting events in real time. When a medical emergency occurs inside the jail, that same telecommunicator may have to leave the console to perform CPR on an inmate or address an urgent jail disturbance—placing themselves at personal risk, interrupting constant supervision, and breaking radio/911 coverage for everyone else. A one-size-fits-all mandate ignores this reality. It doesn't add capacity; it overloads the few people we have with too many critical tasks at once, jeopardizing both scene safety and system availability.

There is also an important structural issue policymakers should understand. In Kansas, telecommunicators are not state-certified the same way peace officers are. Law enforcement operates under a statewide certification and training framework; dispatchers do not. Imposing a medical instruction mandate on non-certified, chronically understaffed PSAPs—without adding capacity—invites burnout, attrition, and reduced coverage at the exact time 911 callers need us most.

Training remains part of the picture—and we support it. Training is finite and manageable, but it is not zero-impact: it must be scheduled, refreshed, and paired with ongoing quality assurance, skill retention, protocol updates, and medical oversight. In one-seat and thinly staffed centers, even short, recurring training and QA cycles press on already scarce coverage. That is why

training must be coupled with staffing, funding, and statewide medical direction—not mandated in isolation.

This is why law enforcement and PSAP leadership across Kansas support Senate Bill 379. We support expanding CPR and emergency medical instruction. What we do not support is a mandate that ignores staffing shortages, funding gaps, and the absence of statewide medical oversight. This bill expands lifesaving capability while allowing PSAPs to manage competing duties safely and responsibly, rather than forcing critical functions to compete for attention during emergencies. And importantly, SB 379 reduces the cost and risk barriers first, so participation can grow without compulsion. That is how you deliver outcomes—not just expectations.

As the sheriff of a rural county with a one-seat PSAP, I see this reality every day. On Monday of this week, while listening to another county's radio traffic, I heard a dispatcher advise their deputies to hold all radio traffic because they needed to deal with an issue in their jail. There was no drama—only professionalism—but it said everything about capacity. When a single dispatcher has to pause the rest of the system to manage a jail situation, it underscores how thin the margin already is. Policy should support that reality, not ignore it or add to it. Senate Bill 379 does exactly that.

A key strength of SB 379 is that it incentivizes participation by removing barriers. The bill provides good-faith liability protections for telecommunicators and PSAPs that voluntarily provide T-CPR or EMD using approved protocols and training. These protections reduce personal and agency risk, make participation practical for small centers, and promote consistency and confidence across the state.

Equally important, the bill reduces costs for PSAPs by enabling statewide purchasing for medical direction, quality assurance, protocols, and training, and by creating a dedicated T-CPR/EMD fund so agencies aren't forced to cannibalize core 911 technology dollars. Incentives work: when we lower costs and protect good-faith actions, PSAPs say "yes."

I respect the American Heart Association's lifesaving mission—and we share it. However, the current mandate-focused position reflects a perspective shaped largely from one side of the system and does not fully recognize the opportunity to gain compliance by removing barriers—nor the staffing, training, and split-duty challenges facing small PSAPs. The problem is not whether telecommunicators can be trained; training is finite and manageable. The problem is that many centers lack the staffing, funding, medical direction, liability clarity, and real-time support necessary to safely integrate medical instruction amid competing duties. A mandate does not resolve those conflicts—it forces telecommunicators to choose between simultaneous critical duties, increasing risk to the caller, the responder, and the telecommunicator. Senate Bill 379 addresses that reality by building support and capacity first.

A rigid mandate may look decisive on paper. In practice, it can increase turnover, mandatory overtime, and vacancy gaps—setting small one-seat and even two-seat PSAPs back years. Good policy starts with the reality on the console. Senate Bill 379 does that.

One of the greatest strengths of the SB 11 Exploratory Committee's plan, now reflected in Senate Bill 379, is its emphasis on centralized statewide medical direction and quality assurance under the Kansas 911 Board. Today, many PSAPs—especially small and rural centers—do not have realistic access to a qualified medical director, nor the staffing or funding capacity to sustain protocol-required quality assurance. Expecting 119 separate PSAPs to independently contract physicians, manage quality assurance programs, and absorb ongoing costs is inefficient and inequitable.

This plan solves that problem directly. Centralized medical direction and statewide quality assurance options promote consistency, improve patient safety, protect telecommunicators, reduce total taxpayer cost through economies of scale, and avoid building 119 separate silos—while still preserving local operational control.

Voluntary participation is not a weakness; it is an intentional and necessary feature. This reflects what sheriffs and PSAP leaders consistently report statewide. It is not reluctance—it is operational reality. Voluntary participation does not mean inaction. It means PSAPs are invited into a system where barriers have been removed—where medical direction, quality assurance, training access, funding, and liability protections are already in place—so participation is practical rather than punitive. Under this model, PSAPs can adopt T-CPR quickly, move toward EMD as capacity allows, or partner with other PSAPs through call transfer when that is the safest option.

The committee recommends implementing this approach in two phases:

- Phase 1 — Establishes the foundation with centralized medical oversight and protocol approval, T-CPR training delivered through the Kansas 911 Board's learning management system, good-faith liability protections for participating PSAPs/telecommunicators, and a flexible quality assurance framework. These components can be implemented in a timely fashion.
- Phase 2 — EMD builds on that foundation: either state-provided EMD guide cards or statewide purchasing contracts for commercial protocols, along with expanded medical oversight and quality assurance to support EMD call handling.

This phased approach works for Kansas because it meets PSAPs where they are.

The Numbers That Matter

- Today, 68 PSAPs provide EMD—52 in-house and 16 through transfer—while 51 PSAPs provide neither T-CPR nor EMD. Many of those PSAPs are one-seat operations.
- About 1/4 of 1% (≈0.25%) of all 911 calls are CPR-eligible and could require T-CPR, while about 25% of calls benefit from structured EMD assessment.
- Those realities make statewide support essential for safety and proficiency.

This plan also protects core 911 readiness. The dedicated T-CPR/EMD fund prevents PSAPs from cannibalizing the technology dollars that keep systems operational. Statewide purchasing reduces costs and increases consistency.

Finally, it increases access. Phase 1 expands T-CPR without delay, while Phase 2 builds a sustainable path to EMD. Where transfer partnerships are the safest solution, this plan clarifies the rules and supports the PSAPs willing to accept that responsibility.

The Plan Before You (as recommended by SB 11 and proposed in SB 379)

- Establish statewide medical direction and statewide quality assurance options under the Kansas 911 Board.
- Authorize statewide purchasing, allowing the Board to contract for medical direction, quality assurance, protocols, and training at scale.
- Create and fund a dedicated T-CPR/EMD account so PSAPs are not forced to divert core 911 technology dollars.
- Provide good-faith liability protections for telecommunicators and PSAPs engaged in voluntary T-CPR or EMD.
- Preserve voluntary participation, remove barriers, and clarify PSAP-to-PSAP contracting authority for T-CPR/EMD services.
- Consider prohibiting untrained medical instructions, ensuring medical guidance is delivered only through approved protocols by properly trained personnel.

Senate Bill 379 moves Kansas in the right direction—respecting local operations and safeguarding the men and women who answer 911 calls.

I respectfully urge you to advance legislation that:

- establishes statewide medical oversight and quality assurance options;
- authorizes statewide purchasing;
- creates and funds the T-CPR/EMD account;
- provides good-faith liability protections for voluntary participants; and
- preserves voluntary participation.

This is the balanced path that expands access, saves lives, and sustains the professionals who answer our calls—often alone, often underappreciated, and always committed to serving Kansas.

Thank you, Chair and Members.

Sheriff Jacob O. Welsh
Chase County, Kansas