

Attached please find a letter of testimony written on behalf of the fire chief of the Avon Volunteer Fire Department, along with supporting documentation.

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Connecticut General Assembly
Joint Committee on Public Health
Legislative Office Building
Hartford, CT 06106

March 18, 2014

Dear Public Health Committee,

This letter is written in respectful opposition to Sections 1 and 2 of SB #439, AN ACT CONCERNING RECOMMENDATIONS OF THE EMERGENCY MEDICAL SERVICES ADVISORY BOARD.

On behalf of the fire chief of the Avon Volunteer Fire Department, I would respectfully argue that SB 439, drafted in response to the recommendations of my esteemed colleagues in the medical and pre-hospital care community, ignores the broader context regarding pre-hospital medical incident management and patient care. One might conclude from a cursory review of the bill that it is meant to protect victims of emergency incidents from the malicious interference of bystanders or others with the execution of EMS provider duties, or to ensure that the highest level of service available is provided to our citizens. However, the vague and broad nature of the verbiage of the Act reveals a subtle but intentional opportunity to circumvent established command and decision-making authority on fire department-staffed emergency scenes. Despite its initial appearance, incident management, not patient safety, is at the very heart of this proposed legislation.

In 2014, the Incident Command System (ICS), a key part of the National Incident Management System* (NIMS), is widely accepted as the system by which public safety personnel respond to and manage public safety emergencies, especially on the large scale or in cases of multi-casualty incidents. It is the standard upon which public safety incident management roles are measured and frequently modeled, including the CT Multi-Casualty Incident Guidelines (attached) developed by the Connecticut Mass Casualty Care Committee and approved by the Connecticut EMS Advisory Board, which were specifically revised August 30, 2007 to conform to and reflect the principle of NIMS.

SB 439 undermines the authority of an incident commander (IC, as defined by the Incident Command System), regardless of the agency from which the IC is established, by giving statutory authority of a subordinate provider or agency to override, ignore, or operate outside the boundary of the established incident command structure or system simply by claiming that such system "interferes" with that providers provision of emergency medical care.

To better understand the afore-mentioned broader context when considering this bill and its effects, it would be helpful to understand the common circumstance in which this bill might be applied. An incident in which a provider may be called to render medical care (as referred to in the bill) that involves the fire service, is better considered as a fire or police emergency that involves the need for emergency medical services. This, by definition, may not be an isolated

medical emergency, but require the expertise and coordinated efforts of a variety of different types of public safety personnel. To establish an Act that would elevate the authority of a single paramedic or provider agency of singular expertise above all others is shortsighted and contrary to the public interest.

It should be clear to anyone reviewing this proposed legislation that within an emergency incident there can be only one incident commander, with all other authority delegated from that position. The position of authority on any emergency scene in Connecticut where a fire department or company is responding has already been established by Connecticut General Statutes under Title 7, Chapter 104, Section 7-313e as the fire officer in charge. Except in the case of a unified command (which is not addressed within this proposed legislation) which includes a paramedic or other appropriate EMS organization representative, any EMS provider or agency summoned to respond to an emergency scene that involves medical contingencies are by necessity and by organizational construct both subordinate to and responsible to the fire incident commander or his designee.

Similarly, Section two speaks directly to *decision making*, which may be correlated to *management*, and does not adequately address that patient care decisions be made within the confines of a delineated command structure. While it makes intuitive sense that a higher trained person should be responsible for patient care decisions, circumstances do occur, and not infrequently, when the appropriateness of such decisions conflict with the broader needs of the incident, and scene management. Nowhere is this better illustrated than in the context of an active shooter situation or other tactical environment. In addition, Section 2 of the proposed Act raises a different concern, which wrests authority for patient care from a fire-based EMT and redirects it directly to an EMT from a transporting agency regardless of the readiness of the patient for transport. Again, if this particular action is the most appropriate it should be by the order of the incident commander or his designee based on the appropriateness of circumstance and the needs of the incident, not by inflexible statute. Thirdly, and especially in the circumstance of multi-casualty incidents, the transfer of patient care from a provider on scene to a "provider with a higher classification of licensure or certification upon such provider's arrival on scene" may be neither feasible nor prudent. To etch such actions into statute rather than to leave such decisions up to the discretion of the commander on scene would not appear to be in the public interest.

On behalf of the fire chief of the Avon Volunteer Fire Department, I urge all members of the Joint Committee on Public Health, and all concerned legislators, to reject this legislation as proposed.

Sincerely,



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*On February 28, 2003, the President issued Homeland Security Presidential Directive 5 (HSPD-5), "Management of Domestic Incidents," which directed the Secretary of Homeland Security to develop and administer a *National Incident Management System* (NIMS). This system provides a consistent nationwide template to enable Federal, State, tribal, and local governments, nongovernmental organizations (NGOs), and the private sector to work together to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity. **This consistency provides the foundation for utilization of NIMS for *all* incidents, ranging from *daily occurrences* to incidents requiring a coordinated Federal response.**

HSPD-5 requires all Federal departments and agencies to adopt NIMS and to use it in their individual incident management programs and activities, as well as in support of all actions taken to assist State, tribal, and local governments. The directive requires Federal departments and agencies to make adoption of NIMS by State, tribal, and local organizations a condition for Federal preparedness assistance (through grants, contracts, and other activities), and as such has become a pervasive system in use throughout the state, and near standard for both volunteer and "career" fire department operations.

Multi-Casualty Incident (MCI) Guidelines

April 11, 2001

Developed by the Connecticut Mass Casualty Care Committee

Approved by the Connecticut EMS Advisory Board

Revised August 30, 2007 to conform to the NIMS

Consistent with New England EMS Council for EMS mass casualty incident management guidelines and the incident command system guidelines, the guidelines for declaring and operating at a mass casualty incident are:

1. Assess and avoid exposure to existing dangers.
2. A mass casualty incident will be declared by the incident commander if the community defined threshold number of patients are exceeded. The threshold will be when the number of patients or the extent of their injuries alters the normal day-to-day operations. Approval of the local MCI plan is indicated by endorsement by the local fire, police and EMS authorities.
3. The Incident Commander or designee will notify the dispatcher and the nearest hospital of type of MCI and estimate of number and type of patients. This communication will take place as soon as possible after the operations begin. In addition, the appropriate official will
 - a. Request additional EMS, fire and police assistance as needed.
 - b. Request all area hospitals be notified.
4. The EMS personnel arriving at the scene will report immediately to the Incident Commander or, if designated, the Operations Chief or, if designated, subordinate officers designated by the Incident Command System to manage the EMS operations. All EMS officers defined below will wear identification vests to designate their assigned roles. In the following order, the positions will be appointed as qualified personnel become available:
5. A Medical Group Supervisor or Medical Branch Director will be appointed by the Incident Command System. This appointment will be made by the Incident Commander or authorized designee (Operations Chief or other). Reports to the Incident Command System. Responsible for all EMS operations, including patient triage, treatment, and transportation. This individual is authorized to appoint the remaining four EMS officers (listed below).
6. A Triage Unit Leader will be appointed by the Medical Group Supervisor. This individual is responsible for rapidly and continuously assessing all patients. This officer continues in this role as long as patients remain at the scene. This person is authorized to assign available personnel to provide treatment for immediately life saving conditions for patients who will benefit from immediate care with the resources available. Treatment is limited to:

Airway - by reposition patient's head/neck/shoulders

Bleeding - rapid pressure dressing if blood is observed moving from a wound

7. Triage Personnel will be appointed by the Medical Group Supervisor. These individuals will rapidly triage and apply tags to all patients using SMART tags.

Tag categories are:

RED, PRIORITY 1: Conditions requiring immediate transport by ambulance to prevent jeopardy to life or limb and which will not unduly deplete personnel/equipment resources. (Examples include patients showing signs of shock, major blood loss, multiple system injuries, severe respiratory distress and significant head injuries.)

YELLOW, PRIORITY 2: Conditions not requiring immediate transportation to prevent jeopardy to life or limb, but which eventually require ambulance transport to hospital for attention. (Examples include single system fractures, sprains, strains requiring X-rays, and open wounds which are not continuously bleeding but which require sutures).

GREEN, PRIORITY 3: Minor conditions not requiring the patient to be seen at a hospital. (Examples include small abrasions, bruises or those patients not presenting with any injuries).

BLACK, DEAD: Patients who are clinically dead (without respirations or pulses before the patient is located in the treatment area. Witnessed arrests in the treatment area, if sufficient personnel are available, will receive CPR and remain tagged in the RED category.

8. **TREATMENT UNIT LEADER** will be appointed by the Medical Group Supervisor. This individual will set up and supervises the treatment areas. A differentiation of patients tagged Red will be made by utilizing the blue corner for expectant on the tag for unresponsive patients expected to expire, and only the Red for responsive patients. This officer will oversee the designation of the prioritization of patients to be taken from the treatment area for transportation. Coordinates with Patient Transportation Unit Leader to prepare for loading the patients for transportation. This officer may communicate with the hospital and medical control the individual characteristics of patients in the treatment area remaining in priority need for transportation. Such information will include, tag number, approximate or actual age, gender, chief complaint or problem, and the expected time for completion of treatment resulting in the patient being loaded for transportation.
9. **Transportation Unit Leader** will be appointed by the Medical Group Supervisor. This individual will coordinate ambulances in loading area. Oversees the appropriate loading of patients in basic life support, intermediate and paramedic transport ambulances. Logs the information on patients loaded in ambulances and times they were released for transportation. Instructs ambulance personnel not to contact hospitals unless medical control is required for condition change. Notifies hospital of estimated time of arrival. Records departure times, hospital notification times, patient ID#s and destination of transporting vehicles.
10. As the operations continue, the Medical Group Supervisor will provide oversight of the subordinate EMS officers, providing periodic updates to the incident command post. When a sufficient number of ambulances with their crews have arrived on scene and all of the

remaining patients are receiving care, the Medical Group Supervisor will consider recommending to the Incident Commander that the MCI operations be terminated. If this is ordered, the Medical Group Supervisor will instruct all personnel to treat and transport the patients they are then working on, but to log in with the Patient Transportation Unit Leader before leaving for a hospital.

SUGGESTED SCENE ORGANIZATION

