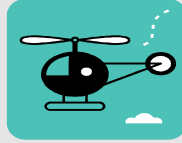


Air Medical Transport Task Force



Group II Minutes

January 16, 2008

(after Main Task Force meeting)

Attendance:

Graham Pierce (**Co-Lead**); Rachel Hanks-Saphore; Ray Ramirez; Joe Barger; Tony Pallitto; John Telmos; Mitch Dattilo; Eric Goetz; Randy Lyman; Lisa Abeloe ; Berend Meelker; Lisa Epps; Patty Murphy; Brian Warner, Margaret Tole

EMSA Staff:

Bonnie Sinz



Notes from Main Task Force:

Data

- Use standard electronic format for data submission to LEMSA
- Developing Air Service data set using CEMISIS/NEMISIS data standards

Professional Roles

- Flight Nurse role needs BRN input
- Flight Medic with optional advanced scope of practice
 - ✓ Questions regarding public provider liability if unable to meet a “flight medic” standard
 - ✓ Concern voiced over perception of dual standard depending on ability to provide a more advanced scope of practice

Role of Medical Director

- LEMSA Medical Director has authority
- Provider and LEMSA Medical Directors need to collaborate
- Need to address role of specialty centers in determining field care

Quality Improvement

- All should participate
- Open communications with internal and regional QI
- Need strong role for LEMSA Medical Director

Cross Jurisdictional Issues

- Home Base accreditation and scope of practice
- Need to define “home base” and costs
- Follow destination policies of receiving LEMSA
- Need temporary assignment approval process
- Provider agreements
- Need strong QI process
- Need to address out-of-state services that is not mutual aid



Assignments:

Bonnie Sinz: 1. Invite BRN to next Group II meeting
2. Follow up with EMSAAC on Cross-Jurisdictional Medicine concepts proposed
by group

Rachel Hanks: Provide 90-day temporary accreditation process from NorCal EMS Agency
(DONE)

Tom Ronay: Draft “conflict of interest” language for Role of Medical Director document

Ray Ramirez
Rachel Hanks: Revise Attachment A (for provider) based on discussion

Joe Barger
Eric Rudnik
Rachel Hanks: Revise Joe Barger’s document (Attachment B) on Medical Direction based on
group discussion

Joe Barger
Bob Hesse
David Magnino: Draft Air Provider data set based on QI needs; identify which CEMSIS data
elements are not applicable

Joe Barger: Collect Air Provider quality indicators

Rachel Hanks: Provide NorCal EMS Agency’s “authorized RN” policy

Graham Pierce
Mike Antonucci: Draft language for Flight Medic under the direction of RN/MD; check with Group
I on dispatch issues



Next Meetings:

March 10, 2008 (10:00am – 3:00pm) at EMSA Sacramento

Group II only

April 10, 2008 (10:00am – 3:00pm) in Sacramento (location to be announced)

Main Meeting with time for group meetings

ATTACHMENT A

- 4.30 A “Multi-County Service Provider” is a provider of “Air Ambulance Services” or “Air Rescue Services” who operates in multiple counties under the accreditation status of a single “Authorizing EMS Agency.”
- 4.31 As used in this Guideline, the “Classifying EMS Agency” is defined in Title 22, Chapter 8, §§100288, and the “Authorizing EMS Agency” is defined in §§ 100289.
- 4.32 “Multi-County Accreditation” as used in this Guideline applies only to an “Air Ambulance Service” as defined in Title 22, Chapter 8, §§ 100285, or “Air Rescue Service” as defined in Title 22, Chapter 8, §§ 100286.
- 4.33 A “Multi-County Service Provider” as used in this Guideline means an “Air Ambulance Service” or “Air Rescue Service” who enters into a written agreement
- (1) A Standard Drug and Equipment List
 - (2) A single ALS treatment protocol
 - (3) A single expanded scope-of-practice
 - (4) A single standard data submission requirement
 - (5) A single Quality Improvement review process
- 4.34 Nothing in this Guideline shall require an “Authorizing EMS Agency” to accept the “Multi-County Accreditation” status of a “Multi-County Service Provider” desiring to provide service within the “Authorizing EMS Agency’s” jurisdiction.
- 4.35 Nothing in this Guideline shall prohibit an “Authorizing EMS Agency” from enacting policies, procedures, or protocols that allow for a “Multi-County Service Provider” to provide EMS aircraft services within the “Authorizing EMS Agency’s” jurisdiction.
- 4.36 For the purposes of this Guideline, each “Authorizing EMS Agency” may designate a “Designated Dispatch Center” within it’s jurisdiction to coordinate requests for air ambulance or air rescue response, including requests for “Multi-County Service Providers.”
- 4.37 An “Air Ambulance Service” or “Air Rescue Service” who provides primary service to multiple local EMS agency jurisdictions may select a single “Authorizing EMS Agency” to accreditate the employer’s state-licensed EMT-P personnel.
- 4.38 The accrediting “Authorizing EMS Agency” of a “Multi-County Service Provider” may charge the appropriate fees to cover costs associated with any “multi-county accreditation” requirements as set forth in Title 22, Chapter 8, §§ 100300(7).

ATTACHMENT B

Aeromedical Task Force – Description of current medical control/oversight processes and concept for improvement for air providers that respond in multiple LEMSA's.

Current practices with regard to prospective medical control:

Air providers that currently practice in multiple counties currently find wide variation in the application of medical oversight.

Personnel/Scope Issues:

Paramedics: For those providers that utilize paramedics, there are some LEMSAs that require accreditation of any paramedic that provides services in the county. Other LEMSAs accept the accreditation of paramedics that are based in another LEMSAs (though it is not clear that there is written agreement to provide for this between the two LEMSAs). Other LEMSAs do not accredit or attempt to address accreditation through another agency. As well, some LEMSAs specifically allow only the local paramedic scope of practice while others accept the scope that the paramedic uses in their accredited county. Other LEMSAs do not address scope issues in a formal manner.

Registered Nurses: One LEMSA, NorCal EMS, has required authorization of registered nurses as a part of their approval process for air providers. There appear to be no other LEMSAs that currently require this (to the knowledge of the group 2 aeromedical task force members). Current language in state statute and regulation concerning EMS and nurses provides for the oversight of prehospital care provided by RN's. It appears that the process of authorization required by NorCal EMS is supported by law. Many LEMSAs have not attempted any regulatory effort with regard to RNs – at least some agencies have interpreted current statute and regulation to preclude this. Discussions have been held between Dr. Aristeiguieta and the BRN – the positions of both and whether an agreement has been reached between these parties needs to be confirmed.

Treatment Guidelines and Equipment Requirements:

Similar to the oversight encountered with regard to personnel, some LEMSAs review and direct the treatment guidelines and equipment that air providers utilize, while others accept the approval process of other LEMSAs. Other LEMSAs do not review or approve these items. Some LEMSAs have interpreted statute as limiting the ability to direct the treatment guidelines of air agencies that have nurse-only staffing.

Current practices with regard to retrospective medical control:

Case Review:

Air providers are frequently requested to review or comment on specific incidents by EMS agencies. Lack of compliance with these requests or lack of satisfaction with response to incidents have been identified in specific instances reported to EMSA, though there appears to be no evidence that concerns of LEMSAs are frequently ignored.

Quality Assurance/Quality Improvement Activities and Data:

Air providers are included in QA/QI activities on a regular basis in some LEMSAs, intermittently in others, and not at all in others. Some LEMSAs have specific requirements or contracts for data reporting –

a number of different formats are required in order to meet the differing requirements of LEMSAs. Some LEMSAs receive copies of PCRs and summary activity sheets but do not proscribe the format of reports. Air providers encounter numerous and varied QI indicator processes among LEMSAs. Air providers are currently not widely familiar with the emerging data standards of NEMSIS and CEMSIS.

Rationale for consideration of a more coordinated approach to multi-LEMSA air providers:

Considerable energies are placed into the compliance with multiple LEMSA requirements for paramedic accreditation, scope of practice, treatment guidelines, quality assurance/improvement activities and data. For a specific air provider, time and resources spent on these compliance issues could be better utilized in improved training and quality review processes with a more unified set of treatment guidelines, equipment, and data requirements. Uniform data reporting would allow statewide, local, and provider-based reports and indicators and potentially concentrate efforts to improve care on the most important issues. The patchwork framework of the current process is not geared well to optimize QI.

Proposal for organization of multi-LEMSA air providers prospective and retrospective medical oversight:

The widely accepted practice of utilizing the accreditation of “Host LEMSA” for paramedics could be formalized as a process that multi-LEMSA air providers would use. The concept of “Host LEMSA” accreditation, treatment guidelines, equipment requirements would mean that air providers could concentrate efforts in obtaining accreditation, training, and equipping their ships with a single standard. The treatment guidelines or even specific equipment would not need to be identical across different air providers, though it is felt that with an emphasis on uniformity in provider’s guidelines and equipment would likely lead to more overall uniformity. It is felt that the minor variances among LEMSAs guidelines and among providers are likely not clinically significant but that overall uniformity among all providers may be difficult to establish as an initial step. The development of treatment guidelines/equipment lists should allow provider medical directors input as well as input from other affected LEMSAs (not required but encouraged). Completion of the QI loop should be accomplished with the input of all involved LEMSAs to the Host LEMSA with regard to system improvements in treatment guidelines and equipment (those who do not choose to participate would actually benefit by the efforts of others). A possible QI structure is described in an attached diagram. Each LEMSA would have access to locally pertinent data as well as pooled data of the provider organizations, and with well-developed data sets and indicators that are uniform among providers, direction of the QI process could be intelligently done in a collaborative process. Aggregate data and indicators would be able to be compared by LEMSA, air provider, and statewide. Individual personnel QI issues would require the actions of the Host LEMSA in coordination with involved LEMSAs.

Issues of concern:

The definition of an air provider’s “base” needs to be determined – does an air provider with several bases need to have multiple Host LEMSAs or can a single LEMSA (e.g. at center of business operations) be recognized as the “Host LEMSA.” This structure would place an onus on “Host LEMSAs” that is now perhaps partially in place and incompletely manifested in terms of review/feedback from other LEMSAs. It remains to be determined if additional resources or costs of oversight could be managed via current fee structures / review mechanisms. Because authorization of RNs only is done in one region currently, there is no defined “Host LEMSA” for air providers with RN-only staffing. Those providers would need to identify “Hosts” to work with. If authorization became a widespread phenomenon, then Hosts could be identified (to potentially avoid need for authorization in all counties that were deciding to authorize).

This structure would require cooperation and agreement among LEMSA and LEMSA medical directors. Some give and take may be needed to reach the ideal, though it is felt that the goal of a more unified approach would optimize quality review and feedback. The willingness of LEMSAs to cooperate with a coordinated approach is unknown at this time. The statutory responsibility for oversight of care by the LEMSA medical director means that use of the “Host LEMSA” approach could be scuttled if a significant number of LEMSAs chose not to participate. A written agreement between LEMSAs to maintain the structure would not supercede statutory language, but could at least indicate a commitment (albeit non-binding) to the structure. This structure does not address providers that may have interface with a single LEMSA. Some air providers with limited numbers of LEMSAs to deal with might choose to consider individual relationships with LEMSA’s, though the data reporting structures would likely be of great value across all providers, whether serving single or multiple LEMSAs.