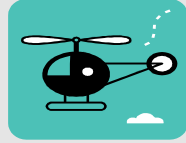


Aero Medical Transport Task Force



Group II Minutes January 7, 2008

Attendance:

Graham Pierce (**Co-Lead**); Lisa Abeloe; Kara Davis (phone); Rachel Hanks-Saphore (phone); Ray Ramirez; Eric Rudnick (phone); Joe Barger; Robert Hesse; David Magnino; Tony Pallitto (phone); John Telmos; Berend Meelker; Myron Smith (phone); Tom Ronay (phone); Tom Hornsby; Michael Antonucci; Robert Donovan (**Co-Lead**); Mitch Dattilo; Eric Goetz; Jan Ogar (phone); Gary McCalla (phone); Dr. Martinez (phone); Chris Leonne (phone)

EMSA Staff:

Bonnie Sinz

Introductions: All present were introduced.

Approval of Agenda: Add 1) discussion on “conflict of interest” for Medical Director and 2) Will Air Transport Regulations be revised.

Approval of October 17, 2007 Minutes: Approved with amended “next meeting” information.



Conflict of Interest for Medical Director: There was discussion on whether it would be considered a “conflict of interest” if a LEMSA Medical Director was also and Air Provider Medical Director?

- A conflict of interest issue is to be analyzed and resolved at the LEMSA level
- The final document from this Task Force can reference this opinion

Action Item: Dr. Ronay will draft language for the document



Regulations: The question was raised as to whether the EMS Authority plans on opening the Air Transport Regulations for revision.

The EMS Authority will take under advisement any recommendations for regulatory revisions from the Air Transport Task Force.



Cross-Jurisdictional Medicine:

- 1) Propose that personnel maintain home base accreditation and Scope of Practice**
- 2) Cross-jurisdiction medicine be allowed for 90 day temporary assignment (with option for extension with home base LEMSA approval)**
- 3) Home base LEMSA and receiving LEMSA be notified prior to assignment change**
- 4) Personnel to follow receiving LEMSA's destination policies**
- 5) Standard form to be developed for personnel cross-jurisdictional request (to be approved by base LEMSA)**
- 6) Personnel who are temporarily assigned to be paired with permanent personnel:**
 - mandatory for air ambulance**
 - preferable for air rescue**

Bonnie provided the above information to Bruce Lee, as the EMSAAC President, and has not received a response.

Action Item: Bonnie to follow up with Bruce

Eric Rudnik and Joe Barger discussed with EMDAC. EMDAC will need a draft document to review and comment on. Medical Control language should be written separately and submit for comment rather than waiting for the full document. EMSA will need to approve prior to request for comment. Process for draft documents:

Group II ⇔ Main Task Force ⇔ EMSA ⇔ EMSAAC/EMDAC

Ray Ramirez presented a discussion document on "Multi-County Service Provider":

- All LEMSAs would have the opportunity to participate in this process
- LEMSA would retain authority to deny acceptance of a provider based on LEMSA policies/procedures and regulations/statute
- Could this process be established without regulatory change? Provide in guidelines document
- Exceptions should be avoid to maintain the goal of standardization
- Need to deal with "individual" accreditation vs. "provider" approval

Action Item: Rachel will provide the group with NorCal's individual accreditation policy

- Regarding "A single ALS treatment protocol":
 - ✓ ACLS should be the same across jurisdictions
 - ✓ There is a need for standardized protocols
 - ✓ National Air Medical Protocols are now under development
 - ✓ It will be difficult to get Medical Directors to agree on a single protocol – Provider Medical Director should provide recommendations
- Destination Policy: LEMSA of Origin vs. LEMSA of destination – needs further discussion

Action Item: Ray to revise the document based on discussion – found as Attachment A



Role of the Medical Director discussion:

- LEMSA Medical Director has the statutory authority for Medical Direction
- Need to have collaboration between LEMSA and Provider Medical Directors
- Need standing invitation for LEMSA Medical Director to attend Provider QI meetings
- Guidelines need to address role of Trauma Center Director in determining appropriate trauma-related protocols
- LEMSAs needs to work together when there is cross jurisdiction
- State QI Process (when active) will help with collaboration between all entities
- State can assist when there is an unresolved issue at the local level; however, should try to be resolved at local level first
- CalAMS may be able to assist with opinion when needed

Action Item: Joe Barger to refine his Medical Direction document (Attachment B) based on discussion for next meeting.



Quality Improvement/Data discussion:

- State data collection provides for common language
- Data set may be modified to be appropriate for Air Providers
- Explore a standard electronic format for data submission to LEMSA
- If LEMSA data needs exceed CEMSIS – work with provider re: additional data needs
- Need to check if there are air industry data needs that are not addressed in CEMSIS or NEMSIS
- Data collection needs to be flexible enough to change as industry needs change
- Current problem with electronic systems not being able to communicate with each other – creates problem transferring electronic records
- Data needs to answer quality of care questions, eg. was a given procedure/medication indicated?
- Provider needs to participate in “home” LEMSA QI process and by invitation to other LEMSA QI meetings when provider’s cases are up for review

Action Item: 1) Joe Barger, Bob Hesse and David Magnino will draft air provider data set based on QI needs with room to grow; will identify which CEMSIS data elements are not applicable 2) Joe Barger will have Pat Frost (QI Coordinator for Contra Costa EMS) collect Air Provider QI Indicators



Professional Roles discussion:

- BRN representative needed – Bonnie has asked with no response to date
- NorCal EMS uses “authorized RN” process for Air Providers

Action Item: Rachel will provide NorCal policy for group

- Regarding Certified Flight Paramedic (FPC):
 - ✓ Do paramedics need an expanded scope of practice?
 - ✓ How can we make it easy for RN and EMT-P to work together as a team without placing the paramedic's license in jeopardy?
 - ✓ FPC with exam; can take 200-300 hours of study to prepare for exam
 - ✓ NorCal EMS requires FPC and CFN (certified flight nurse)
 - ✓ May develop package for advanced scope of practice for flight medic to be considered by EMDAC (similar to the IFT advanced scope of practice document)
 - ✓ Consider an expanded scope of practice for paramedic when teamed with RN; need to be careful with language avoid perception of a "superior service"
 - ✓ Should there be a tiered dispatch for those units with expanded scope of practice?
 - ✓ Need to study malpractice insurance issues with expanded scope of practice
 - ✓ Final team configuration CANNOT create a non-competitive environment
 - ✓ Should this expanded scope be considered for IFT only to avoid issues with Air Rescue?

Action Item: Graham Pierce and Mike Antonucci will draft language for IFT only; check with Group I regarding dispatch issues



Next Meetings:

January 16, 2007 (10:00am – 3:00pm) in Rancho Cucamonga

Main Meeting with time for group meetings

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

Group II only

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.