Joint Legislative Audit and Review Commission
Review of Air Medevac Services in Virginia – June 30, 1999
Recommendations

Recommendation	Current Status – July 14, 2004
1. All out-of-state air Medevac providers doing business in Virginia should be afforded the opportunity to be members of the Medevac Committee.	1) Invitations have been extended to out-of-state Medevac services to include: Wake Forest Air Care Duke University Life Flight Washington Hospital Medstar US Park Police NC Baptist Hospital Air Care UNC Carolina Air Care Maryland State Police Wings Rescue Invitations and minutes will be issued again to all 'fringe' agencies. At the July 14, 2004 meeting of the Medevac Committee, thirteen (13) voting member programs were identified. Medevac Committee meetings are open to out-of-state services. The committee determines there was no need at this time to establish an associate membership status.
2. The Virginia Department of State police should assess the need and costs to acquire one or more larger helicopters for its air Medevac program. The State Police should report its findings to the House Appropriations and Senate Finance Committees prior to the 2000 Session.	Department Bell 206 helicopters have been replaced with Bell 407 helicopters. An American Eurocopter BK 117 twin engine helicopter was received August 2001.
3. The Department of State Police should have an additional paramedic or flight nurse for MedFlight I so that two medical personnel are present on the helicopter for all air Medevac	The VSP has added an additional medically trained member to each of their flights starting in CY2001. In addition, Virginia EMS regulations (1/15/03) now require 2 air medical personnel for all flights.

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flights. Chesterfield County or MCV Hospitals should provide the additional medical staff.	
4. MCV Hospitals should move its helipad to an appropriate location with direct access to the emergency room.	MCV's helipad was relocated to the Main Hospital roof in FY2001
5.The Department of Medical Assistance Services should re-evaluate reimbursement rates paid to air Medevac providers. The rates should be based on the costs incurred by air Medevac providers in Virginia. The rates should at least equal the costs incurred by the Department of State Police MedFlight operations.	DMAS re-evaluated reimbursement rates paid to Medevac providers in 1998. DMAS is being asked to re-evaluate and update these rates again for FY2004.
6.The Department of State Police should assess its need for additional helicopter service statewide, and report its findings to the House Appropriations and Senate Finance Committees prior to the 2001 Session.	The directive was made to VSP who indicated that it was felt that this was in the domain of the Department of Health. The Department of Health is currently (07/04) administering a survey to address perceived needs and current utilization of air medical services in Virginia.
7. The Department of State Police, Chesterfield County, MCV Hospitals, and Bristol Regional Medical Center should assess the potential for billing medical patients flown by MedFlight I and MedFlight II. Billing for only the medical costs incurred should be considered. This assessment should be reported to the House Appropriations and Senate Finance Committees prior to the 2000 Session.	VSP correspondence with the FAA stated that "any costs for the medical services are paid directly to the providers. No charge is made for the use of the aircraft…..the charges made for medical services are the same as the charges that would be made for the same service in an ambulance or other surface vehicle. If the charges were enhanced because of the aviation nature of the program….that would be a form of compensation and commercial certification would be required"
8. The medical staff for MedFlight I should be provided by MCV Hospitals. Medical staff would include paramedics, flight nurses, and the medical director position.	VDH supports but does not require Medevac programs to utilize a medical director affiliated with a designated trauma center.
9. The Virginia Department of Health regulations should require that an air Medevac provider give	90 day notice of an Medevac provider's intention to cease providing service is required (EMS

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VDH/OEMS 90 days or longer advance notice prior to ceasing service.	Regulations, 1/15/03) for all Virginia licensed agencies. VSP would, within its aviation assets, provide an appropriate helicopter and pilots to the effected area, if a need were identified. This arrangement would be of a short-term nature. The Medevac Committee should be consulted prior to any decision to relocate air medical assets. The long-term solution continues to be a private-public cooperative operation.
10.The Virginia Department of Health and the Department of State Police should develop a contingency plan with input from air Medevac providers indicating how air Medevac services would continue in the event that an existing air Medevac provider ceases operation. The contingency plan should include several options for continued provision of air Medevac services. The plan should be completed prior to the 2001 General Assembly, and include: a. An agreement that immediately upon a provider ceasing service, the adjoining air Medevac providers who provide mutual aid in the affected area should provide coverage as feasible within the former provider's service area. Alternatively, State Police could commence air Medevac services to accident scenes in the service area of the former provider by transferring (or leasing on an emergency basis) a helicopter, and making arrangements with nearby rescue, fire departments, or hospitals, to provide the necessary medical staff. b. An agreement between the adjoining providers	VSP has agreed to provide aircraft and pilot to an area that has lost air Medevac service. This is with the understanding that the locality will provide the medical crew, supplies, equipment, and all FAA required flight and safety training, and that funding will have to be identified and allocated for continued service. This was reaffirmed at the 7/16/03 Medevac Meeting.

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as to who will handle inter-facility transfers after a provider ceases operation. c. A determination about whether and under what conditions the State Police will provide additional air Medevac coverage. d. The plan should consider the fiscal impact of all included options and the sources of funding to be provided on an emergency basis.	
11.The Board of Health, in conjunction with the Virginia Department of Health (VDH), should provide a statewide Emergency Medical Services Plan triennially as required by the Code of Virginia. The plan should identify issues of concern to EMS providers and recommend strategies for addressing these concerns.	A 5 year Virginia Emergency Medical Services Plan was developed in 1997, updated in 1998, approved in 1999 by the State EMS Advisory Board and the State Board of Health, and is being revised for FY2005.
12. The Virginia Department of Health (VDH) should play a stronger role in the planning and coordination of air Medevac services. For example, VDH should assist the Department of State Police (DSP) in identifying areas of the State that may require DSP to provide air Medevac services, such as the Lynchburg-Route 29-Danville Corridor. Appropriate data collection should be incorporated in VDH planning and coordination activities.	VSP Medflight III began operations in the Lynchburg – Danville corridor in Sept. 2001. The Medevac Committee is addressing identifying underserved areas in Virginia. The Department of Health is currently (07/04) administering a survey of licensed EMS agencies and hospitals to address perceived needs and current utilization of air medical services in Virginia. Flight data for "missed" air medical flights has been collected since 2002. A biostatistician position was created and filled within OEMS in October 2003 to analyze collected data for functional use.
13. A memorandum of agreement should be	VDH has contacted and obtained information from

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developed which would enable the Virginia Department of Health to obtain from the Virginia Department of Transportation the locations of wireless communication and other towers located in the State's right-of-way. This information along with all updates should be provided to the air Medevac programs.	VDOT pertaining to public right-of-ways. A representative from VDOT attended the spring 2003 meeting of the Medevac Committee to answer questions about the placement of communications towers in public right-of-ways. Letters need to be sent to local zoning officials to receive information on towers located on private land.
14. The Virginia Department of Health should examine additional steps to ensure that oversight of air Medevac providers is adequate. The requirement that air Medevac providers have written mutual aid agreements should extend to out-of-state providers doing business in Virginia. The Department should monitor the effectiveness of the mutual aid agreements, and the frequency of their use, by collecting the appropriate data.	Mutual aid agreements are required for all Virginia licensed agencies as stated in the Virginia EMS Regulations (12VAC 5-31) placed in effect 1/15/03. The legal consequences of such agreements should be examined. The potential exists for written agreements to be interpreted as a contract between parties. These agreements are required between all agencies that share a common border. In October 2001, the Medevac Committee compiled and produced an informational guide profiling each of the participating public and private air medical providers in the state. The Medevac Committee acknowledged at their July 14, 2004 meeting the need to update this guide (Provision of Air Medical Evacuation Services – A Guide for Prehospital and Hospital Emergency Medical Services.)
15. The Virginia Department of Health should evaluate the Medevac Committee voluntary standards during the current review of the Emergency Medical Services Regulations and incorporate those provisions they deem necessary to the effective operation of air Medevac services.	Medevac Committee voluntary standards were evaluated and current applicable standards were incorporated into the EMS Regulations placed in effect 1/15/03.
16.As a part of its current revision of the air Medevac regulations, the Virginia Department of	Virginia queried North Carolina, Tennessee, Maryland, and Pennsylvania regarding their air Medevac standards

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Health should identify the best regulatory standards in use in other states and incorporate them as appropriate in the revised Virginia standards.	before finalizing the current EMS Regulations placed in effect 1/15/03.

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