# Virginia Department of Health
# Response to JLARC Recommendations From The
# Review of Air Medevac Services in Virginia

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Recommendation (1): VDH agrees that all out-of-state medevac providers doing business in Virginia should be afforded the opportunity to be members of the Medevac Committee.

Recommendation (2): VDH has no position.

Recommendation (3): VDH supports utilization of two air medical crew members for all routine patient transports.

Recommendation (4): For patients to reap maximum benefits of medevac transport, the receiving hospital helipad needs to be in close proximity to the facility's physical location.

Recommendation (5): VDH agrees that the Department of Medical Assistance Services should re-evaluate reimbursement rates paid to air medevac providers and that rates reflect costs incurred by providers in Virginia.

Recommendation (6) :VDH has no position.

Recommendation (7): VDH has no position

Recommendation (8): VDH supports medevac program utilization of a medical director affiliated with a designated trauma center. (Would like to agree with the entire recommendation, but not at the risk of alienating Chesterfield FD if our comments became public knowledge.)

Recommendation (9): VDH agrees that we should require, through regulations, that an air medevac provider give us 90 day or longer advance notice prior to ceasing service.

Recommendation (10): VDH recognizes the need to develop a contingency plan for continued air medevac services should a provider cease operation. The plan must address fiscal impact and the potential need for emergency allocation of general funds. VDH will collaborate with the Department of State Police to develop such a contingency plan prior to the 2001 General Assembly.

> (a) VDH agrees that existing air medevac programs could cover a former program's service area on a relatively short-term basis. Mutual aid agreements may facilitate this coverage. Any mutual aid agreement should outline an expanded service area that is time-effective and determined to be safe by the provider's lead pilot. Mutual aid agreements should be utilized only on a very short-term basis.

Should the Department of State Police commence air medevac services in the geographic location of a former provider, air medical crew members must be appropriately licensed and/or certified and credentialed. Prior to independent functioning, all new flight crew members must complete: appropriate helicopter safety training (internal and external to the aircraft); specialized survival training specific to the geographic location; and appropriate orientation to scene and interfacility transports as well as day and night flying.

(b) VDH has no position.

(c) VDH has no position.

Recommendation (11): VDH respectfully requests that the Legislative Analysts of the Joint Legislative Audit and Review Commission provide more guidance in their expectations of the content and scope of the statewide Emergency Medical Services Plan. VDH contends that a lack of quality in the air medevac service is not demonstrated in the JLARC Report.

VDH contends that the report does not fairly present the role and involvement of the Office of EMS and the Virginia Department of Health in planning and coordination of air medevac services in Virginia.

a) OEMS and VSP collaborated to ensure the introduction and passage of legislation which amended the Code to include "establishing a statewide air medical evacuation system which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate state agencies."

b) Private medevac services had already been established throughout Virginia with the exception of Central and Southwest Virginia. Efforts by OEMS and VSP identified coverage deficiencies that led to the Code amendment. This provided the authorization for VSP to establish an Aviation Unit and provide air medevac service. The intent was to establish a "statewide system of coverage" – not a replacement of existing services.

c) OEMS formed the State Medevac Committee, played an early role in coordination and facilitation, planning, staff liaison, and support of committee activities.

d) OEMS authored the first Air Medevac Service Plan in 1986.

e) OEMS arbitrated and mediated communications and correspondence among Virginia's Air Medevac Services.

f) In 1987 OEMS began the development of rules and regulations governing air medevac capabilities, vehicle specifications, equipment and supplies for licensure of rotary and fixed-wing aircraft. Rules and Regulations Governing Licensure of Rotary and Fixed-Wing Aircraft Services were promulgated by the Board of Health in 1990.

g) OEMS produced a statewide Landing Zone (LZ) Directory. This directory documented all identified heliports in Virginia by longitude and latitude coordinates, communication frequencies, hospital, applicable phone numbers, hazards and obstacles (towers, wires, etc.). The recognition of hazards and obstacles led to the development of the LZ Directory.

h) Voluntary Standards for Air Medevac Services were adopted in 1991.

i) OEMS conducted a Comprehensive Review of Rules and Regulations in 1994, pursuant to Executive Order Number Thirteen (94).

j) OEMS has directed policy development involving air medevac services.

k) The OEMS 5-Year-Plan, was adopted by the State EMS Advisory Board on November 13, 1997 as the EMS System Plan for Virginia. This plan addresses all EMS System Attributes included in the EMS Agenda for the Future, National Highway Safety Administration. It includes goals for air medevac services.

l) Planning and Coordination activities have not been absent, but very evident since the 1983 EMS Plan. The 1986 Virginia Air Medevac Plan was written to specifically address planning and coordination of the medevac system. OEMS developed a Six-Year-Plan in 1987, 1988 and 1989 - pursuant to Governor's directive - included objectives and strategies for air medevac services. Subsequent plans have not been approved through the administrative process as regulations, but have been written, produced and adopted administratively and/or by the State EMS Advisory Board.

Recommendation (12): VDH agrees that it should assume a stronger role in the planning and coordination of air medevac services. VDH recognizes the need for appropriate data collection. VDH also recognizes the urgent need for additional funds and personnel to develop and maintain an appropriate data management system.

Recommendation (13): VDH agrees in the need to obtain wireless communication and other towers from the Department of Transportation. VDH would urge this transpire through a Memorandum of Understanding between the Commissioners of the aforementioned Departments.

Recommendation (14): VDH will examine additional steps to ensure that oversight of air medevac providers is adequate. Although we can encourage drafting of mutual aid

agreements from out-of-state providers who operate within the Commonwealth, we cannot "police" across state boundaries. VDH again recognizes the urgent need for additional funds and dedicated personnel to ensure appropriate and adequate oversight, planning, coordination, licensure and regulation of air medevac services.

Recommendation (15): VDH will review the Medevac Committee Standards (1991) for appropriate inclusion in regulations. Many existing standards are appropriate for regulations. However, other standards, dynamic and evolving, require the flexibility for rapid alteration that cannot occur in the administrative process environment.

Additional items for consideration:

The report (page 28) assumes that all patients are delivered to the air medevac provider's primary base hospital. In fact, all programs deliver patients to hospitals outside their health care system.

Please note that as out-of-state programs service Virginia, in-state programs also service border states.