History of Air Medical Services in Virginia

1981 – Virginia's first air medical evacuation service (Life-Guard of America, Inc.) was dedicated in Salem, Va.

Virginia Commonwealth University (VCU) Health System formerly known as Medical College of Virginia (MCV) was first Level One Trauma Center designated by the state.

A federal block grant permits statewide funding for all EMS Regional Councils.

February 25, 1982 – Nightingale completed its first mission. Nightingale began service as the 38th hospital-based (Sentara Norfolk General Hospital) air medical helicopter program in the U.S.

April 1, 1984 - Med-Flight I began operations and responds to calls for assistance in a 60 mile radius of Richmond.

1984 – Pegasus is founded, part of the University of Virginia Health System.

1986 – State Medevac Committee of the State EMS Advisory Board completed a State Medevac Plan that addresses the coordination of the various services within the state and sets forth expectations in terms of utilization, safety, flight crew training, recording keeping and evaluation.

January 1, 1987 - Med-Flight II began operations and responds to calls for assistance in a 60 mile radius of Abingdon.

1989 – HJ 318 Recognized the need for a study to determine the feasibility of establishing a medevac program on the Eastern Shore of VA.

1990 – HD 60

Document Summary

- Report Published -

View PDF Version*

House Document No. 60

PUBLICATION YEAR 1990

Document Title

The Feasibility of Establishing a Helicopter **Medevac** Service on the Eastern Shore of Virginia

Author

Department of Health

Enabling Authority

HJR 318 (Regular Session, 1989)

Executive Summary

A resolution was introduced to the 1989 Session of the General Assembly in response to concerns over an inadequate air medical transport system to meet the needs of trauma patients on the Eastern Shore of Virginia. House Joint Resolution 318, patroned by Delegate Robert Bloxom, recognized the need for a study to determine the feasibility of establishing a **medevac** program on the Eastern Shore.

House Joint Resolution 318 called for the State Department of Health to conduct a study on the feasibility, need, access to, and costs of an emergency medical evacuation system for physical trauma patients for the Eastern Shore." The resolution required completion of the study and submission of findings and recommendations to the Governor and the 1990 Session of the General Assembly. HJR 318 was approved, and the State Department of Health was requested to conduct the study.

1996 – HJ139. Continuing the Joint Subcommittee Studying Certain EMS Training and Governance Issues.

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Studying Certain Emergency Medical Services Training and Governance Issues be continued. The joint subcommittee shall review the progress on the implementation of its recommendations; assess the impact of such recommendations on the emergency medical services system; review and evaluate the status and needs of the air Medivac system, including funding implications; and consider further changes as may be necessary to ensure the viability of the system. The membership of the joint subcommittee appointed pursuant to House Joint Resolution No. 437 (1995) shall continue to serve; however, vacancies shall be filled in accordance with HJR No. 437 (1995).

The Division of Legislative Services shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1997 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents. The direct costs of this study shall not exceed $4,050.

1997 – HJ636 Establishing a joint subcommittee to study the Air Medivac System in the Commonwealth

RESOLVED by the House of Delegates, the Senate concurring, that a joint subcommittee be established to study the Air Medivac System in the Commonwealth. The joint subcommittee shall be composed of 9 legislative members as follows: 5 members of the House of Delegates, of whom three members shall be representative of the joint subcommittee established pursuant to HJR No. 139 (1996), and the House Committees on Health, Welfare and Institutions and on Appropriations to be appointed by the Speaker of the House; and 4 members of the Senate, of whom three members shall be representative of the joint subcommittee established pursuant to HJR No. 139 (1996), and the Senate Committees on Education and Health and on Finance to be appointed by the Senate Committee on Privileges and Elections.

The joint subcommittee shall perform the following:

1. Review the administration and operation procedures of the public and private air Medivac providers;

2. Identify, compare, and evaluate the mission, operation, and funding of public and private Medivac programs;

3. Assess the availability of air medical evacuation services to citizens throughout the Commonwealth;

4. Determine the feasibility of expanding the public and private air Medivac system to provide services to underserved regions of the state, or in areas where the continuation of such services by private providers may be uncertain;

5. Determine the need for and ways to assist providers in providing more effective and cost-efficient services;

6. Evaluate the administrative protocols to facilitate better coordination and the determination of the need for air Medivac services;

7. Determine the need to improve or enhance the accountability of providers for the costs associated with the delivery of services;

8. Assess the need for statewide alternatives and options to ensure the continuation of air Medivac services throughout the Commonwealth;

9. Identify areas of service overlap and the impact on service delivery and health care costs; and

10. Consider such other related issues as the joint subcommittee may deem appropriate.

The direct costs of this study shall not exceed $6,750.

Item 16I in the 1998 Appropriations Act requested JLARC to conduct a comprehensive review of air medevac services in VA.

House Document 14 – October 1999 and report published in 2000. Review of Air Medevac Services in VA.

House Document No. 14 (Oct 21, 1999) View PDF Version*
PUBLICATION YEAR 2000

Document Title
Review of Air **Medevac** Services in Virginia
Author
Joint Legislative Audit and Review Commission

Enabling Authority
Appropriation Act - Item 16 I. (Regular Session, 1998)
Executive Summary
Air medical evacuation (**medevac**) services play an important role in the spectrum of emergency medical care. The key advantage of the providers of these services is that they quickly deliver a high level of medical care to the site of an accident or medical emergency, and rapidly transport seriously ill and injured patients to higher levels of medical care. In addition, in many accident situations, the **medevac** crew provides the highest level of medical care on site.

More than 3,700 air **medevac** missions were flown in Virginia during 1998. The seven air **medevac** programs based in Virginia flew 90 percent of these missions. Three of the Virginia providers are operated by police agencies and four are affiliated with major hospitals. Five out-of-state air **medevac** providers also respond to calls in Virginia.

Item 16.I. of the 1998 Appropriations Act directed the Joint Legislative Audit and Review Commission (JLARC) to study the air **medevac** system in Virginia. The study was prompted by concerns about the adequacy of funding for air **medevac** providers and about continued availability of the service statewide.

This study found that air medevac coverage is adequate in most areas of the State. However, there are some inconsistencies in service that should be addressed. The location of the helipad for MCV Hospitals should be moved to a more appropriate site closer to the emergency room. Additionally, the Department of State Police should arrange for two medical crew members, the industry standard, upon acquiring a larger helicopter for its MedFlight I service.

In terms of the adequacy of funding, this review found that although commercial providers reported operating a loss, it appears unnecessary for the State to subsidize the commercial provider at this time. However, because there is a concern as to whether all programs can remain in operation over the long term, the Department of Health and Department of State Police should develop a contingency plan for the continuation of air medevac services in any part of the State which loses service. Further, the Department of Health needs to strengthen planning and coordination activities for the air medevac system. Reviewing the regulations governing the air medevac providers is a necessary step, as well as updating the statutorily-required statewide Emergency Medical Services plan.

2000 – Delegate Orrock introduced HB 1243. The bill was carried over to 2001 session. Due to the lack of action, the bill was ultimately left in HWI and did not come up during the 2001 session of the VA General Assembly.

Summary as introduced:
Virginia Medivac Authority. Directs the Board of Health, with input from the State Emergency Services Advisory Board, to organize the Virginia Medivac Authority to ensure that all regions of the state have access to medivac services. The Board must hold at least two public hearings before organizing the Authority. The Authority will be governed by a 15-member organization

that consists predominantly of participants, i.e., public or private entities currently operating medivac services in Virginia. The Authority is given broad powers, including contracting, hiring, suing and being sued, and charging fees, etc., for its services. The revenues raised by the Authority must be geared to cover the expenses of its operation. The Board must promulgate emergency regulations.

history | hilite | pdf

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HOUSE BILL NO. 1243

Offered January 24, 2000

A BILL to amend and reenact §§ 32.1-111.3 and 32.1-111.10 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 4 of Title 32.1 an article numbered 2.3, consisting of sections numbered 32.1-111.17, 32.1-111.18, and 32.1-111.19, relating to the Virginia Medivac Authority.

Patron-- Orrock

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-111.3 and 32.1-111.10 of the Code of Virginia are amended and reenacted and the Code of Virginia is amended by adding in Chapter 4 of Title 32.1 an article numbered 2.3, consisting of sections numbered 32.1-111.17, 32.1-111.18, and 32.1-111.19, as follows:

§ 32.1-111.3. Statewide emergency medical care system.

A. The Board of Health shall develop a comprehensive, coordinated, emergency medical care system in the Commonwealth and prepare a Statewide Emergency Medical Services Plan which shall incorporate, but not be limited to, the plans prepared by the regional emergency medical services councils. The Board shall review the Plan triennially and make such revisions as may be necessary. The objectives of such Plan and the system shall include, but not be limited to, the following:

1. Establishing a comprehensive statewide emergency medical care system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

2. Reducing the time period between the identification of an acutely ill or injured patient and the definitive treatment;

3. Increasing the accessibility of high quality emergency medical services to all citizens of Virginia;

4. Promoting continuing improvement in system components including ground, water and air transportation, communications, hospital emergency departments and other emergency medical care facilities, consumer health information and education, and health manpower and manpower training;

5. Improving the quality of emergency medical care delivered on site, in transit, in hospital emergency departments and within the hospital environment;

6. Working with medical societies, hospitals, and other public and private agencies in developing approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be served more appropriately and economically;

7. Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of health manpower involved in emergency medical services;

8. Consulting with and reviewing, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs;

9. Establishing a statewide air medical evacuation system *to be implemented through the Virginia Medivac Authority, established in Article 2.3 (§ 32.1-111.17 et seq.) of this chapter,* which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate ~~state~~ *public and private* agencies;

10. Establishing and maintaining a process for designation of appropriate hospitals as trauma centers and specialty care centers based on an applicable national evaluation system;

11. Establishing a comprehensive emergency medical services patient care data collection and evaluation system pursuant to Article 3.1 (§ 32.1-116.1 et seq.) of this chapter;

12. Collecting data and information and preparing reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.1-340 et seq.); and

13. Establishing a registration program for automated external defibrillators, pursuant to § 32.1-111.14:1.

B. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and interhospital Trauma Triage Plan designed to promote rapid access for pediatric and adult trauma patients to appropriate, organized trauma care through the publication and regular updating of information on resources for trauma care and generally accepted criteria for trauma triage and appropriate transfer. The Trauma Triage Plan shall include:

1. A strategy for implementing the statewide Trauma Triage Plan through formal regional trauma triage plans developed by the regional emergency medical services councils which can incorporate each region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A of this section. The regional trauma triage plans shall be implemented by July 1, 1999, upon the approval of the Commissioner.

2. A uniform set of proposed criteria for prehospital and interhospital triage and transport of trauma patients, consistent with the trauma protocols of the American College of Surgeons' Committee on Trauma, developed by the Emergency Medical Services Advisory Board, in consultation with the Virginia Chapter of the American College of Surgeons, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Emergency Medical Services Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se.

3. A program for monitoring the quality of care, consistent with other components of the Emergency Medical Services Plan. The program shall provide for collection and analysis of data on emergency medical and trauma services from existing validated sources, including but not limited to the emergency medical services patient care information system, pursuant to Article 3.1 (§ 32.1-116.1 et seq.) of this chapter, the Patient Level Data System, and mortality data. The Emergency Medical Services Advisory Board shall review and analyze such data on a quarterly basis and report its findings to the Commissioner. The first such report shall be for the quarter beginning on July 1, 1999. The Advisory Board may execute these duties through a committee composed of persons having expertise in critical care issues and representatives of emergency medical services providers. The program for monitoring and reporting the results of emergency medical and trauma services data analysis shall be the sole means of encouraging and promoting compliance with the trauma triage criteria.

The Commissioner shall report aggregate findings of the analysis annually to each regional emergency medical services council, with the first such report representing data submitted for the quarter beginning July 1, 1999, through the quarter ending June 30, 2000. The report shall be available to the public and shall identify, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region. The Advisory Board shall ensure that each hospital or emergency medical services director is informed of any incorrect interfacility transfer or triage, as defined in the statewide plan, specific to the provider and shall give the provider an opportunity to correct any facts on which such determination is based, if the provider asserts that such facts are inaccurate. The findings of the report shall be used to improve the Trauma Triage Plan, including triage, and transport and trauma center designation criteria. The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-116.2. Such data or information in the possession of or transmitted to the Commissioner, the Advisory Board, or any committee acting on behalf of the

Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

C. Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of this section, an appropriate amount not to exceed the actual costs of operation may be charged by the agency having administrative control of such aircraft, vehicle or other form of conveyance.

§ 32.1-111.10. State Emergency Medical Services Advisory Board; purpose; membership; duties.

A. For the purpose of advising the State Board of Health concerning the administration of the statewide emergency medical care system and emergency medical services vehicles maintained and operated to provide transportation to persons requiring emergency medical treatment, and reviewing and making recommendations on the Statewide Emergency Medical Services Plan, there is hereby created the State Emergency Medical Services Advisory Board, which shall be composed of twenty-four members. The membership of the Advisory Board shall be appointed by the Governor and shall include one representative of each of the following groups: Virginia Municipal League, Virginia Association of Counties, Medical Society of Virginia, Virginia Chapter of the American College of Emergency Physicians, Virginia Chapter of the American College of Surgeons, Virginia Chapter of the American Academy of Pediatrics, one member of either the Emergency Nurses Association or the Virginia Nurses' Association, Virginia Hospital Association, Virginia State Firefighters Association, State Fire Chiefs Association of Virginia, Virginia Ambulance Association, Virginia Association of Governmental Emergency Medical Services Administrators, and Virginia Association of Public Safety Communications Officials; a consumer who shall not be involved in or affiliated with emergency medical services in any capacity; one representative from each of the eight regional emergency medical services councils; and two members of the Virginia Association of Volunteer Rescue Squads, Inc. Appointments may be made, at the discretion of the Governor, from lists of three nominees submitted by such organizations and groups, where applicable. To ensure diversity in representation, the Governor may request additional nominees from the applicable organizations and groups. In no case shall the Governor be bound to make any appointment from among any list of nominees. Each regional emergency medical services advisory council shall submit three nominations, at least one of which shall be a representative of providers of prehospital care. Each member shall be designated as serving as the representative of one of the aforementioned groups.

B. Members serving on the State Emergency Medical Services Advisory Board on January 1, 1996, shall complete their current terms of office. Thereafter, appointments shall be made to accomplish the restructuring of the Advisory Board according to the membership in effect on July 1, 1996, and shall be for terms of three years or the unexpired portions thereof in a manner to preserve insofar as possible the representation of the specified groups. No member shall serve more than two successive terms. Effective July 1, 1997, no individual representing any one or more of the groups named in subsection A who has served as a member of the State Emergency Medical Services Advisory Board for two or more successive terms for any period or for six or

more consecutive years shall be nominated for appointment or appointed to the Advisory Board unless at least three consecutive years have elapsed since such individual has served on the Advisory Board.

The chairman shall be elected from the membership of the Advisory Board for a term of one year and shall be eligible for reelection. The Advisory Board shall meet at least four times annually at the call of the chairman or the Commissioner.

C. The State Emergency Medical Services Advisory Board shall:

1. Advise the State Board of Health on the administration of this article;

2. Review and make recommendations for the Statewide Emergency Medical Services Plan and any revisions thereto;

3. Review the annual financial report of the Virginia Association of Volunteer Rescue Squads, as required by § 32.1-111.13;

4. Review, on a schedule as it may determine, reports on the status of all aspects of the statewide emergency medical care system, including the Financial Assistance and Review Committee, the Rescue Squad Assistance Fund, the regional emergency medical services councils, *the Virginia Medivac Authority*, and the emergency medical services vehicles, submitted by the State Office of Emergency Medical Services; ~~and~~

5. Advise the Board on the requirements for the registration and training for the use of automated external defibrillators pursuant to § 32.1-111.14:1*; and*

6. Assist the Board in implementing the Virginia Medivac Authority by, among other things, designing the services and defining the participants and the terms of such participation.

Article 2.3.
Virginia Medivac Authority.

§ 32.1-111.17. Definitions.

As used in this article:

"Advisory Board" means the State Emergency Medical Services Advisory Board established in § 32.1-111.10.

"Authority" means the Virginia Medivac Authority, a nonprofit corporation having a governing board that predominantly consists of participants in Virginia's medivac service.

"Board" means the Board of Health.

"Medivac" means a helicopter equipped for emergency medical services of the sick or injured, particularly in instances of multiple trauma, while such persons are being evacuated to a hospital.

"Participants" means a public or private medivac service operating in Virginia on January 1, 2000.

§ 32.1-111.18. Authority created.

The Board of Health may organize the Virginia Medivac Authority, hereinafter called "the Authority," to ensure that all regions of the Commonwealth are covered by appropriate medivac services. Prior to organizing the Authority, the Board shall hold at least two public hearings and obtain input from the State Emergency Medical Services Advisory Board. After obtaining public comment and the input of the Advisory Board, the Board shall promulgate regulations for the establishment and organization of the Authority. The Board's regulations may provide for a contract with a nonprofit corporation, as defined in § 32.1-111.17.

The Board's regulations shall provide for a fifteen member governing organization for the Authority and shall establish the membership to consist predominantly of participants in the medivac system.

A majority of the members of the Authority's governing organization shall constitute a quorum and an affirmative vote of a majority of its members shall be necessary for any decision or action. No vacancy in the membership of the governing organization shall impair the right of a quorum to exercise all the rights and perform all of the duties of the Authority. The members of the governing organization shall serve without compensation, but may be reimbursed for the actual expenses incurred in the performance of their duties, as appropriate under state law and with such funds as may be available.

§ 32.1-111.19. Powers of the Authority.

A. The Authority shall be deemed to be a public instrumentality exercising public and essential governmental functions to provide for public health, safety and welfare. The Authority shall:

1. Ensure that all regions of the Commonwealth have access to medivac services and that the medivac system is financially viable and well organized;

2. Adopt bylaws for the regulation of its affairs and the conduct of its business;

3. Adopt an official seal as it deems necessary;

4. Maintain an office or offices;

5. Sue and be sued in its own name;

6. Purchase, lease, equip, maintain, repair, and operate helicopters, emergency equipment, and supplies in order to provide evacuation services to seriously sick and injured persons upon such terms and conditions as it may deem advisable to carry out the provisions of this article;

7. Set and revise as necessary and charge and collect rates, rentals, fees, and other charges for the services and transportation furnished by the Authority and its participants;

8. Acquire in the name of the Authority by gift, or lease-purchase, any helicopters, equipment, and supplies, and acquire such other personal property as it may deem necessary in connection with the performance of its functions;

9. Enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers under this article;

10. Employ such financial experts, accountants and attorneys and such employees and agents as may, in the judgment of the Authority, be deemed necessary, and fix such persons' compensation; and

11. Do such other official acts to carry out the powers granted by this article.

The powers conferred by this section shall only be executed with the funds made available to the Authority through the appropriation act or other source.

B. The rates, rentals, fees, and other charges for the services and transportation furnished by the Authority and its participants, which may be established pursuant to this section, shall not be subject to the supervision or regulation of any state, local or private agencies; however, such charges shall, at all times, be set to be sufficient to pay the cost of maintaining, repairing, and operating the medivac system.

2. That the Board of Health shall promulgate regulations to implement this act within 280 days of its enactment.

September 1, 2000 - Med-Flight III began operations and responds to calls for assistance predominately along the Lynchburg-Route 29 corridors to Danville and in a 60 mile radius of Lynchburg.

2001 – VCU Health air medical transport system begins operation

2003 – Delegate Orrock introduced HB2751. The bill was passed by in HWI with a letter. Presume a letter was sent to Commissioner of Health requesting state EMS Advisory Board to look into this matter further.

HB 2751 Virginia Medevac Authority.
Robert D. Orrock, Sr. | all patrons ... notes | add to my profiles

Summary as introduced:

Virginia Medevac Authority. Directs the Board of Health, with input from the State Emergency Services Advisory Board, to organize the Virginia Medevac Authority to ensure that all regions of the Commonwealth have access to medevac services. The Board must hold at least 2 public hearings and receive input of the Advisory Board before organizing the Authority. The Authority will be governed by a 15-member organization that consists predominantly of participants, i.e., public or private entities currently operating medevac services in Virginia. The Authority is given broad powers, including contracting, hiring, suing and being sued, and charging fees, etc., for its services. The revenues raised by the Authority must be geared to cover the expenses of its operation. The Board of Health is required to promulgate emergency regulations by a second enactment clause.

Full text:

01/17/03 House: Presented & ordered printed 033865876 **pdf**

Status:

01/17/03 House: Presented & ordered printed 033865876
01/17/03 House: Referred to Committee on Health, Welfare and Institutions
01/30/03 House: Passed by in H. W. I. with letter (22-Y 0-N)

The Use and Financing of Trauma Centers in Virginia (HD No. 62) reported that air medevac providers flew a total of 23,000 missions in 2003.

January 2004, Inova Health System partners with PHI to expand Inova AirCare using two (2) Bell 412SP helicopters. Inova AirCare based at Manassas Regional Airport and Spotsylvania County.

LifeEvac based in Richmond opens a second base of operations in Fredericksburg, VA.

February 13, 2004, State EMS Advisory Board unanimously approves State Medevac Mission Statement and Code of Conduct.

Mission Statement – To facilitate communication and cooperation between all air medical services that respond in Virginia ensuring that all patients receive appropriate, timely, safe and professional air medevac services.

Code of Conduct (October 14, 2003) - With regard to medevac missions, Virginia air medical programs recognize the following principles in common and in the following order of priority: (complete document not published)

Safety: All medevac missions will be conducted in the safest manner possible for the crew, the patient, and the general public.
Patient Care: The purpose of each medevac mission is to provide optimal medical care to the patient or patients involved.
System Integration: Optimal care of the critically ill or injured patient requires integration of specific components, one of which is air medical evacuation.

Program Autonomy: Each program will have the opportunity to maintain its respective autonomy and to purse its individual mission profile.

October 2004, State Medevac Committee developed Medevac Utilization Survey that was sent to hospitals and pre-hospital providers. Trends in survey were noted: 1) concerns on equity in use and payment from patients, and 2) concerns about operational protocols for medevac use.

January 10, 2005, LifeEvac II based in Stafford County crashes into Potomac River just south of Woodrow Wilson Bridge after completing a mission to Washington Hospital Center. Paramedic Nicole "Nikki" Kieler and Pilot Joseph Schaffer were killed. Flight Nurse Jonathan Godfrey was injured in the crash, rescued from the water and treated at Washington Hospital Center.

February 4, 2005, State Medevac Committee voted to place a moratorium on new air medical agencies and any expansion of services by existing air medical programs. Special called meeting was held on March 18, 2005 and decision was made to remove the moratorium. The committee voted to develop new EMS Regulations for air medical services using CAMTS regulations and other resources as a guide.

2005 HD57 - Report on the use of funds provided from RSAF for VSP Med-Flight operations

Document Summary

- Report Published -

House Document No. 57
PUBLICATION YEAR 2005

View PDF Version*

Document Title
Report on the Use of Funds Provided from the Rescue Squad Assistance Fund for Aviation (Med-Flight) Operations
Author
Department of State Police
Enabling Authority
Appropriation Act - Item 456 G.1. (Regular Session, 2005)
Executive Summary
Report on the use of funds provided from the Rescue Squad Assistance Fund for aviation (Med Flight) operations.

Colonel Steve Flaherty reported that VSP does not account for Med-Flight costs separately from other aviation expenses. However, through the use of reports supplied by their Aviation Unit, they were able to calculate estimated expenditures in the amount of $3,404,788 that were incurred in FY05 related to Med-Flight Operations. The $1,045,375 provided to VSP from RSAF is used to offset the overall cost of Med-Flight operations.

January 12, 2006, State Medevac Committee voted to adopt draft "Air Medical Regulations"

Medevac Committee begins discussing the possibility of using a Certificate of Public Need (COPN) process for air medical providers in VA. Representative from OAG shared that air ambulance rates, routes and services are preempted by Federal Aviation Administration (FAA) laws. State can regulate the delivery of medical services, staffing requirements, the qualifications of personnel, equipment and standards of sanitary conditions.

Best Practices Committee of the State Medevac Committee presented a plan to the full Medevac Committee of topics that need to be addressed: 9-1-1/PSAP center education, ground and hospital provider education related to the use of air medical services, multiple helicopter responses, establishing a method of performance improvement (PI) and the development of resources to localities and agencies.

February 2007, draft of Air Medical Regulations returned from OAG with comments. State Medevac Committee reviewed twice proposed Medevac Authority bill. Two items consistently suggested; 1) Use data to support planning, and 2) committee believes it can address many of the issues making the air medical industry in Virginia without the establishment of an authority.

April 26, 2007, State Medevac Committee agrees to develop air medical best practices for Virginia. Intent is to create a source of information for the users of the Medevac system and to establish a baseline than can be used to measure the system. Best practices will be developed for: 1) Communications, 2) Initiating a Medevac Response, 3) Launch, 4) Response, 5) Education, and 6) Performance Improvement.

July 26, 2007, Staff from a medevac agency in Denver, CO attended State Medevac Committee meeting and provided a brief description of the "Weather Safe" program used to alert other medevac agencies in the system when a flight is turned down due to weather.

October 25, 2007, State Medevac Committee heard from representative of VHHA about the possibility of using "Web EOC" as a means to show the status/availability of air medical services similar to hospital diversion status.

Medevac Best Practices Committee is set to present three best practices to the full State Medevac Committee for its adoption as statewide best practices. The three practices are centered on dispatching or initiating a Medevac response and include; 1) authorized requestors, 2) requesting Medevac prior to arriving on scene, and 3) requests for air medical service when already on scene.

November 7, 2007, EMS Advisory Board adopts Deliverable 2.1: Dispatch Best Practices Terms developed by Best Practices subcommittee of State Medevac Committee.

February, 2008, Online Landing Zone (LZ) Directory available for use by air medical services.

State Medevac Committee finalizing two best practices – Air Medical Resource Management and Risk Management.

Two new medevac bases in VA. Wings Air Rescue IV out of Marion, VA and PHI Sky Stat II out of Hopewell.

May 16, 2008, The following documents were presented and unanimously approved by the state EMS Advisory Board; 1) Medevac Resources Information – A Guide to Air Medical Services in VA, 2) Medevac Best Practice 2.2.1 Air Medical Resource Management (AMRM), and 3) Medevac Best Practice 2.2.2 Risk Management.

July 2008, Composition of Medevac Committee changed to include consumer representative, hospital representative and operation medical director.

July 3, 2008, Conference call of the Medevac Committee held to review and discuss sharing of safety procedures among all medevac services in VA. Call prompted by significant increase in the number of medevac services nationally in the past two to three month. Medevac services agreed to use FAA VHF radio frequencies to make open air announcements of destinations, headings, and altitudes, and make updated announcements within 10 miles of a facility, in addition to current communication practices.

October 3, 2008, Medevac Summit held in Charlottesville to establish a clear vision for a medevac system in VA and to identify initial strategies for achieving vision. Four tasks were completed: 1) Establish a vision for the future medevac system in VA, 2) Clearly define the critical mission of the state Medevac Committee beyond the requirements of the state Code, 3) Identify strengths and weaknesses of the current system and approach, and 4) Identify potential actions that could be taken to create and maintain an effective medevac system serving the entire state.

January 9, 2009, Strategic planning meeting held in Richmond, VA with state Medevac Committee. Four critical areas for the future of the medevac system in VA were identified; 1) Communications, 2) Regulation/Oversight, 3) Safety (Weather Safe), 4) Helicopter utilization. Subgroups made up of medevac stakeholders were formed to work on these critical attention areas.

May 15, 2009, Completion of first Medevac Committee Strategic Plan announced at state EMS Advisory Board meeting.

August 2009, Four (4) workgroups of the state Medevac Committee meet on a regular basis: 1) Utilization (Project Synergy) continues to work on providing standard education for EMS providers regarding the proper utilization of medevac services, data necessary for project to look at patient length of stay transported by helicopter, decisions to transport by air vs. ground, etc.; 2) Safety (approx.. 60% of services using Weather Safe); 3) Helicopter EMS (HEMS) Regulations; and 4) HEMS Communications.

April 30, 2010 - Med-Flight III program closed. It is now used only for law enforcement operations.

October 28, 2010, Dr. Karen Remley, State Health Commissioner tasked the State Medevac Committee to develop a vision and a five year plan for the future of helicopter EMS in VA. Committee directed to partner with other stakeholders to propose a comprehensive voluntary statewide network committed to safety, access and quality of care.

February 2011, Medevac Committee partners with VHHA and VDEM using WebEOC and creates a portal for helicopter EMS programs. Medevac services will be able to access information and list their availability in cases of an MCI.

May 2011, Draft of recommendations for the future of medevac in VA submitted to VDH administration. Feedback was received leading to revisions of draft document and the involvement of the Medical Direction Committee.

State Medevac Committee develops an educational program for Dr. Remley (Remley Project) that is directed towards physicians on when and how to access Medevac services.

September 2011, EMS Systems Planner at OEMS, working with medevac system stakeholders as well as representatives of the VHHA is building an online landing zone (LZ) directory. Directory includes essential information (latitude and longitude, dimensions and weight capacity) on LZ's for each medical facility, radio frequencies and photos of the LZ site. A hazard notification has been built into the application to notify medevac services about potential hazards (i.e. construction cranes, etc.) There is also a module built in for medevac services to report their air transport status (number of units in service, patient capacity, status of aircraft). Information is essential in MCI's.

November 2011, Over 1,400 turndowns due to weather have been reported since January 2011.

May 2012, There is a push to place hospital LZ information on WeatherSafe to help crews find specific information in a standard format in one location.

October 10, 2012, EMS Regulations (12VAC5-31) effective. Includes updated regulations that apply to air medical services operating in VA.

November 7, 2012, "Physician's Guide to Helicopter EMS Use in VA" presentation included as Appendix in quarterly report to members of the state EMS Advisory Board.

Utilization guidelines/ Launch criteria developed by several national organizations: www.ampa.org , www.aams.org and www.naemsp.org. Virginia Office of EMS, Statewide Trauma Triage Plan.

April 29, 2013, state Medevac Committee meets to discuss State EMS Plan, EMS Regulations, and the model State EMS Guidelines developed by the Association of Air Medical Services (AAMS).

August 7, 2013, state Medevac Committee meets to discuss the model State EMS Guidelines developed by AAMS.

January 24, 2014, state Medevac Committee meets to discuss, review, and revise draft regulations governing air medical services, incorporating State EMS Guidelines (AAMS) were applicable.

February 2014, workgroup of state Medevac Committee continues to review Model State Guidelines document developed by AAMS. Plan is to use document as a resource guide for how Medevac agencies within the Commonwealth should operate.

Working to identify data within VPHIB that can be used for projects related to utilization of air medical services for acute patients (STEMI, Stroke, Trauma) and collaborative education of EMS providers across the State.

February 21, 2014, FAA released new rules and regulations governing Helicopter Air Ambulance Operations. Regulations were to be implemented on April 22, 2014. On April 21, 2014, FAA released notification that the implementation date has been extended to April 22, 2015 in order to give certificate holders sufficient time to implement the new requirements in the regulations.

August 7, 2014, Medevac Response Plan developed by CSEMS Council presented to Medevac Committee. Plan focuses on the appropriate and safe dispatch of air medical services.

Medevac Committee is beginning work on a project focused on ground versus air transport items for cardiac patients (STEMI).

Medevac Committee continues to follow dispatch centers and referring hospitals that seem to be "helicopter shopping" during marginal weather events. Letters are sent by the committee chair to dispatch centers or hospitals that appear to be "helicopter shopping."

May 29, 2015, Preliminary findings on impact on patient outcomes of STEMI patients transported by air versus ground inter-facility transports presented at Virginia Heart Attack Coalition (VHAC) annual meeting in Lynchburg, VA

May 29, 2015 - DOT Guidelines Support State Authority to Regulate Medical Functions of Air Ambulances

In response to recommendations (issued in 2009) by the National Transportation Safety Board (NTSB) intended to improve safety in the air medical transport industry, the Federal Aviation Administration (FAA) issued various resource documents regarding helicopter air ambulance safety and operations (see related items below.)NTSB safety recommendations A-09-102 and A-09-103 specific to the air medical transport of patients with emergency medical conditions were addressed to the Federal Interagency Committee on EMS (FICEMS). New guidelines recently published by the US Department of Transportation (USDOT) Office of General Counsel are in response to A-09-102 and refer to medical standards of care that serve primarily a patient objective as "properly within a state's regulatory authority." The guidelines outline opportunities for state regulations that address outcomes related to:

- the quality of emergency medical care provided to patients
- requirements related to the qualifications and training of air ambulance medical personnel
- scope of practice and credentialing
- maintenance of medical records, data collection, and reporting

- medically related equipment standards
- patient care environments
- EMS radio communications
- medically related dispatch requirements
- medical transport plans including transport to appropriate facilities
- other medical licensing requirements

"Guidelines for the Use and Availability of Helicopter Emergency Medical Transport (HEMS)"describes the regulatory and oversight framework for helicopter air ambulance operations that state emergency medical services (EMS) system planners should consider in developing regulations to help ensure patients receive appropriate medical attention and care. FICEMS recently transmitted these guidelines to the NTSB as a component of its response to A-09-102. The referenced document is now available online.

August 7, 2015, Workgroup of state Medevac Committee formed to draft a one-page LZ safety guideline document that will be submitted to task force that is reviewing the Trauma Designation Guidelines.

November 11, 2015, state Medevac Committee formed workgroup to examine drones, safety implications and how they can affect medevac operations.

Educational tool developed for use by fire departments and EMS agencies educating them on safe landing zone and implications of drones. Paper to be distributed to EMS agencies across VA.

February 5, 2016, Drone workgroup has put together a PowerPoint presentation for education of drone operators across the state. Continue work on STEMI project.

May 6, 2016, quarterly report to state EMS Advisory Board, EMS on the National Scene, contains links to ABC affiliate stations across the nation related to "Air Ambulance Balanced Billing Stirs Industry Response. "

STEMI presentation made to state EMS Advisory Board.

September 21, 2016 - **NASEMSO Releases State Model Rules for Regulation of Air Medical Services**

At its Fall Meeting, NASEMSO announced the release of "State Model Rules for the Regulation of Air Medical Services" to assist states with regulatory language intended to avoid conflict with the Airlines Deregulation Act (ADA) and the possibility of Federal preemption. These model rules are intended to be applied in a manner that would confine their scope to matters solely related to medical care, and not construed in a way that could constitute regulation of aviation safety or economic matters.

- **Download State Model Rules for the Regulation of Air Medical Services**

NASEMSO Air Medical Committee http://www.nasemso.org/Projects/AirMedical/#Documents

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