Nadine Pfeiffer
Division of Health Services Regulation
North Carolina Department of Health and Human Services
2701 Mail Service Center
Raleigh, North Carolina 27699-2700
By email: DHSR.RulesCoordinator@dhhs.nc.gov

Dear Ms. Pfeiffer:

On behalf of Carolinas HealthCare System, I appreciate the opportunity to comment on the proposed change to 10A NCAC 13P .0204. Although we understand the impact of several court opinions, and specifically the 2008 opinion from the Eastern District of North Carolina's federal court, to air ambulance programs, we are deeply concerned that a complete void in the regulation of care delivered in an air ambulance will negatively impact access to quality care for patients in North Carolina. The proposed change to 10A NCAC 13P .0204 does not expand access or reduce cost, and it potentially sacrifices high quality care for our sickest patients. We therefore urge the State to make additional changes to the Administrative Code to address the quality of patient care delivered when a patient is transported in an air ambulance.

Carolinas HealthCare System is one of the largest integrated healthcare delivery systems in the Southeast. CHS is home to a Level 1 Trauma Center, two Level 3 Trauma Centers, and rehabilitation services to aid in the recovery of our most critically ill and injured patients. CHS is committed to providing quality health care to all patients, regardless of ability to pay. Every year, CHS completes 1,800 flights annually and receives many more patients transported by other air ambulance programs to CHS facilities. CHS coordinates 4,500 patient transfers by air ambulance per year, demanding the highest level of emergency care, and thus has a vested interest in the care these patients receive at the pre-hospital point of care. We strongly encourage the State to develop rules consistent with the National Association of State EMS Officials' "Model Rules for the Regulation of Air Medical Services." Specifically we request rules addressing quality, the requirements related to training and qualifications of air ambulance medical personnel, patient care environments, and the medical transport of patients to appropriate facilities.

In order to provide the highest quality of care to patients, any air ambulance program must be required coordinate care with medical facilities who can deliver the appropriate level of care once a patient is delivered. Affiliation with a trauma center is essential to maintaining high quality of care for our citizen patients and should be

required by the State. As North Carolina grows in population, the coordination of care offered by the State's Trauma System provides for high quality care in every hospital where a patient arrives to receive care. The State's Trauma System coordinates critical care services by region, regardless of whether a hospital is designated as a trauma center and irrespective of what mode of transportation brings a patient to the hospital doors. Having air ambulance service completely integrated into care coordination ensures patients arrive at the right place to receive the right care at the right time, which is within that "Golden Hour" (i.e., medical care delivered within an hour of the onset of a trauma is most likely to prevent death). Additionally, air ambulance integration ensures care delivered to any trauma patient cared at a non-trauma facility will be peer-reviewed through the State-mandated Regional Advisory Committees on Trauma, which is an important component of maintaining quality medical care as well as the medical appropriateness of this service.

Each Air Ambulance provider should be required to operate a quality assurance (QA) program evaluating patient care and personnel performance for compliance with the provider's published standards of practice and regulations. Review should be conducted quarterly to assess, monitor and evaluate the quality of patient care provided, and medical directors of air ambulance programs should be required to participate. The State should require documentation as evidence of operation of the QA program.

The North Carolina Administrative Code must be updated to accommodate the changing models of care for critically ill or injured patients as well as advancing medical technology. The mix of skills and practice to care for patients in any ambulance, but particularly one that has wings and can travel greater distances and arrive at a hospital within that "Golden Hour," should be addressed. *Responsibilities of the Medical Director for EMS Systems* 10A NCAC 13P .0403 should be modified to reflect the competence and training for each health professional. Medical directors should be board certified or board eligible in emergency medicine or general surgery. Medical directors for specialty air services (neonatal, pediatric, high risk obstetric) should have a medical director that is board certified or board eligible in emergency medicine, general surgery, neonatology, pediatrics, obstetrics or the specialty for which they director provides medical oversight. Flights should be staffed with two personnel and at a minimum one of which should be a flight nurse with three (3) years of experience caring for critically ill/injured patients and no less than 4,000 hours of experience in an intensive care unit. The air ambulance medical director should be allowed to select the other crew member at his/her discretion from the following: RN, paramedic, respiratory therapist, physician assistant, nurse practitioner, or physician as long as that crew member also has three (3) years of the critical care experience and a minimum of 4,000 hours of experience.

We sincerely hope you will carefully consider this request and implement the proposed air ambulance rules changes in order to provide for the highest quality of care to patients. If you need CHS to provide any additional information or would like to discuss these proposals in greater depth, we would be glad to do so.

Sincerely,