Submitted comments for Standards Changes from the 12th Edition to the 13th Edition Standards

Comments for the FIRST Draft

Comments # 1 - # 32

Closed August 31, 2024

Committee responses are in red.

Date 01/22/2024 #1

Standard # - Suggested Change and Rationale for Change

CHANGE DEFINITION: Accidents – An occurrence associated with the operation of an ambulance/aircraft that takes place between the time any person boards the ambulance/aircraft with the intention of flight/transport and until all such persons have disembarked, and which any person suffers death or serious injury, or in which the ambulance/aircraft was substantially damaged. Substantially damaged is defined as any damage to the aircraft that results in a major repair as outlined in 14 CFR Part 43, Appendix A, of the Federal Aviation Regulations, and documented on an FAA Form 337. This includes missions with a patient on board as well as missions that support the transport service's operations including maintenance, training, fueling, and marketing.

The committee agrees with the recommendation and believes it needs to better address surface vehicles. The recommended changes are (addition wording in underline):

> **Accidents – An occurrence associated with the operation of an ambulance/aircraft that takes place between the time any person boards the ambulance/aircraft with the intention of flight/transport and until all such persons have disembarked, and which any person suffers death or serious injury, or in which the ambulance/aircraft was substantially damaged. For aircraft, substantially damaged is defined as any damage to the aircraft that results in a major repair as outlined in 14 CFR Part 43, Appendix A, of the Federal Aviation Regulations, and documented on an FAA Form 337. For surface vehicles, substantial damage is defined as any damage to the vehicle that takes it out of service, temporarily or permanently. This includes missions with a patient on board as well as missions that support the transport service's operations including maintenance, training, fueling, and marketing.**

Date 01/22/2024 #2

Standard # - Suggested Change and Rationale for Change

01.06.02 page 1.10 ADDITION New #2 # 2. A policy or procedure addresses verification of all new advanced certifications and license. Only those verified may be used within the program's employment."

The committee agrees with the suggestion and will add a new standard:

> **01.06.02, 6. A policy or procedure addresses verification of all new advanced certifications and licenses. Only those verified may be used within the program's employment.**

02.03.07 2. d. page 2.14 Addition Helmets are inspected BY AN APPROPRIATELY TRAINED HELMET INSPECTOR on a regularly scheduled basis - at least annually at a minimum.

The committee agrees with the concept of the suggestion but believes this might take some time for programs to develop their workforce, so “strongly encouraged” would better for the 13th edition. The standard currently reads “Helmet are inspected on a regular schedule basis – at least annually at a minimum.” will be changed to read:

Helmets are to be inspected by an appropriately trained helmet inspector on a regularly scheduled basis and at least annually. Helmet manufacturer training of the designated helmet inspector(s) is strongly encouraged.

Date 01/22/2024 #3

Standard # - Suggested Change and Rationale for Change

The current standard reads: “Supplemental oxygen is available for RW pilots who have the potential to fly more than 30 minutes above 9,000 feet MSL, or as applicable to local topography.”

Revision: 02.03.07 2.h, Page 2.16 Change standard to read

“For programs that operate unpressurized aircraft at altitudes above 9000 feet MSL, the following policies should be developed, implemented, and evaluated through an on-going QMS/SMS process:

o A process to allow flight crew member(s) to become acclimated to high altitude environments at the base elevation and operating altitudes. Process must also consider reacclimating following a prolonged absence at lower elevations.

o Awareness training to recognize, and if necessary, react to any potential hypoxic events.

o If possible, use technology to assist in risk mitigation such as operable autopilot, and NVG equipment, as well as personal monitoring equipment that could assist the flight crew in early detection of hypoxia. o Make supplement oxygen available to flight crew member(s) when operating above 9000 feet MSL for more than 30 minutes.

The committee agrees with the changes and will reword the standard to:

For programs that operate unpressurized aircraft at altitudes above 9000 feet MSL, the following policies should be developed, implemented, and evaluated through an on-going QMS/SMS process:

- **A process to allow flight crew member(s) to become acclimated to high altitude environments at the base elevation and operating altitudes. Process must also consider reacclimating following a prolonged absence at lower elevations.**
- **Awareness training to recognize, and if necessary, react to any potential hypoxic events.**
- **If possible, use technology to assist in risk mitigation such as operable autopilot, and NVG equipment, as well as personal monitoring equipment that could assist the flight crew in early detection of hypoxia.**
- **Make supplemental oxygen available to flight crew member(s) when operating above 9000 feet MSL for more than 30 minutes.**

Date 01/21/2024 #4

Standard # - Suggested Change and Rationale for Change

I respectfully recommend adding a standard that all CAMTS-accredited programs have their information uploaded to, and up to date in, the Emergency Transport Healthcare Operations and Safety (ETHOS) database. I recommend information be updated at least twice per year and more often with any significant base-level alterations including base openings, closing, moves, and aircraft changes. ETHOS is the replacement for the previous ADAMS database. The project is a public/private partnership between Medieval Foundation International, Inc. and multiple national organizations including the American College of Surgeons Committee on Trauma, National Association of EMS Physicians, American College of Emergency Physicians, Air Medical Physicians Association, National Association of State EMS Officials, and many more public and private enterprises. Having a single, comprehensive, and GIS-linked repository of air medical services in the United States is key for important advocacy, operations, and research efforts. Without the ETHOS database, the industry is not armed with important data to inform safe and efficient practices and operations in the future. With the ETHOS database there can be a national repository of air medical service base locations to aid in disaster preparedness among other operational endeavors. For example, the secret service previously used the ADAMS database when planning presidential trips. In addition, national organizations can use the information housed in ETHOS to advocate for patients in a multitude of ways. Without knowing the current landscape of air medical services in the US, we cannot adequately inform future advocacy efforts around patient and aircraft safety, system design, or preparedness. Lastly, the ADAMS data was crucial for many high-impact research projects. Trauma, neuro-critical care, burn, and pediatric literature (just to name a few!) often relies on prehospital data. With the ETHOS data, researchers can continue to publish practice changing research which helps patients and providers alike. Thank you for your consideration.

The committee believes support of the ETHOS data base is important and should be strongly encouraged, but some programs may resist for various reasons. For the 13th Edition the committee suggests the following addition:

01.05.05 Programs are strongly encouraged to report, and keep current, their program information in the Emergency Transport Healthcare and Safety (ETHOS) data base. (https://ethos.aams.org/)

Date 01/23/2024 #5

Standard # - Suggested Change and Rationale for Change

Incorporate reporting of data into the ETHOS database as part of the standards.

The committee believes support of the ETHOS data base is important and should be strongly encouraged, but some programs may resist for various reasons. For the 13th Edition the committee suggests the following addition:

01.05.05 Programs are strongly encouraged to report, and keep current, their program information in the Emergency Transport Healthcare and Safety (ETHOS) data base. (https://ethos.aams.org/)

Date 01/23/2024 #6

Standard # - Suggested Change and Rationale for Change

Suggestion inclusion of new standard the requires participation in the ETHOS air medical resources database and maintaining updated and accurate information in the database. This will ensure a comprehensive understanding of air medical resources and assets in the US and provide CAMTS will an easy and reliable database of accredited programs with accurate base demographics.

The committee believes support of the ETHOS data base is important and should be strongly encouraged, but some programs may resist for various reasons. For the 13th Edition the committee suggests the following addition:

01.05.05 Programs are strongly encouraged to report, and keep current, their program information in the Emergency Transport Healthcare and Safety (ETHOS) data base. (https://ethos.aams.org/)

Date 01/23/2024 #7

Standard # - Suggested Change and Rationale for Change

Addendum - Consider adding the medical elements scoring sheets to the 13th edition addendums.

This suggestion is being referred to the CAMTS Protocol Committee.

Date 01/23/2024 #8

Standard # - Suggested Change and Rationale for Change

03.05.01, Page 3.15 Move the bullet and line to the right as a subsection: "Didactic education that is mission specific and specific to scope of care........."

This was an editing error which will be addressed.

06.05.03 # 4, Page 6.9 The list should be the same as from the RW section but is missing "j"
j. The use of appropriate maintenance ladder stands/fall protection to provide access to the components on the aircraft without risk to the mechanic or damage to the aircraft are strongly encouraged."

This was an editing error, and the committee agrees that the RW and FW sections should be the same. Standard 05.05.03 paragraphs "H", "I" and "J" from the RW section will be copied and pasted into the FW section, 06.05.03.

Date 01/23/2024 #9

Standard # - Suggested Change and Rationale for Change

03.06.01 24. **Page 3.36** What is the reason why vehicle temperatures are different? The same human beings are riding in both types of vehicles.

See response under # 10 below.

Date 01/23/2024 #10

Standard # - Suggested Change and Rationale for Change

03.06.01 24. Page 3.36, What is the process to advocate for clarity in a standard? Specifically, 03.06.01 24. "The interior of the aircraft must be climate controlled to avoid adverse effects on patients and personnel on board.". This is a very vague standard. Here in Arizona, we are experiencing unprecedented heat. I have firsthand knowledge of carriers stating that "putting your hands out the window" counts as climate control. 03.06.01 24A does state "until temperatures are maintained within the range of 50-95 degrees". I think the intention is very clear, that a system must be on the aircraft with the ability to control to the climate to these parameters. I would like to know how a flight nurse, such as myself, would go about advocating for language that states something like "the interior of the aircraft must be climate controlled to maintain a cabin temperature range of 50-95 degrees"

Temperature ranges for the surface vehicle come for the federal KKK specification and are also required by several states. These are outlined in more details in the Reference section of the 12th Standards. There is very little written about temperature control ranges for air medical, particularly helicopters that may be left outside because there is no hangar. At the time the original Standard was written, there were many air medical helicopters without air conditioning. The CAMTS Board is a little less concerned about the actual temperature ranges and more about how the program records, tracks, trends and mitigates extremes. In the first draft of the 13th Edition we will change the word of the standard as recommended and propose one range for all vehicles. THIS IS ALL NEW WORDING. We will see what additional suggestions and comments we receive.

03.06.01 24. To avoid adverse effects on patients and personnel on board, the interior of the vehicle cabin should be climate controlled to maintain a cabin temperature range of 68 – 78 degrees F (20.0 – 25.5 degrees C).

- **a. Thermometer is to be mounted inside the cabin. Electronic thermometers that record temperatures are encouraged.**
- **b. The program has written policies that address measures to be taken to avoid effects of temperature extremes on patients, crew, equipment, and medications on board.**
- **c. In the event cabin temperatures are less than 68 degrees F (20 degrees C) or greater than 78 degrees F (25.5 degrees C), the program requires documentation of mitigating actions and outcomes. These will be reviewed by the program QM process for trends and further improvement actions.**
- **d. For those transports meeting the definition of "long range", additional policies must be in place to address how adequate cabin temperature will be maintained during fueling and/or technical stops to ensure patient, crew, and passenger comfort.**

Date 01/23/2024 #11

Standard # - Suggested Change and Rationale for Change

03.05.01 2. b Page 3.18 Open for discussion. Question asked: "We are pursuing CAMTS Accreditation for our pediatric ICU transport team. One questions we had was whether or not each member of the team (RN and RT) needed to be able to intubate or is acceptable for our team to have the capability of bringing a MD along when needed who is able to intubate and secure an airway?" Standard states "No less than 1 successful live, cadaver, HPS or static mannequin airway management experience per quarter is required for each provider, for each type of airway listed within the program protocols (endotracheal, supraglottic, nasal, etc.) and for each age group in scope of care." The way it is written, is the intent of the Standard to allow the management of an airway with supraglottic an/or bag/mask?

The committee agrees to leave the standard unchanged and that both members of a critical care transport team should be trained to the critical care level, which includes advanced airway skills for those patients that are within their scope of care. This does not necessarily require endotracheal intubation if other advance airways (supraglottic) are in the scope of care, and the providers receive initial skills and quarterly competency verifications as outlined in the Standards.

Date 01/23/2024 #12

Standard # - Suggested Change and Rationale for Change

Please include submission of data and membership in the ETHOS database as a requirement for CAMTS accreditation.

The committee believes support of the ETHOS data base is important and should be strongly encouraged, but some programs may resist for various reasons. For the 13th Edition the committee suggests the following addition:

> **01.05.05 Programs are strongly encouraged to report, and keep current, their program information in the Emergency Transport Healthcare and Safety (ETHOS) data base. (https://ethos.aams.org/)**

Date 01/25/2024 #13

Standard # - Suggested Change and Rationale for Change

All HAA operators should be required to fly aircraft with glass windscreens. It is not acceptable to damage or lose and aircraft or crew due to a bird strike. Weight and costs should not outweigh the survivability of an impact in the air.

The committee agrees this would be difficult to impossible to retrofit existing aircraft. Glass windscreens are heavier, require more superstructure, and may reduce the visual field for the pilot. Windscreen design is improving and helmets, with visors, are required within the standards.

Date 01/25/2024 #14

Standard # - Suggested Change and Rationale for Change

01.02.02 6. Page 1.2 Insurance For US operations conducting flights outside of the US, a customs bond appropriate to the size and type of aircraft in the amount that covers any unexpected costs based on port of entry. Comment: A Customs Bond must, by CBP regulation, be in the name of the operator. Can't be in the name of the medical provider. Need to reword.

The committee agrees to change the wording to:

> **01.02.02 6.** Insurance For U.S. operations conducting flights outside of the US, a customs bond, **in the name of the operator**, appropriate to the size and type of aircraft in the amount that covers any unexpected costs based on port of entry.

01.04.02 Page 1.4 Conflict of Interest The BOD, administrative and management staff are encouraged to complete an annual conflict of interest statement or form disclosing any actual or potential conflicts. Comment: Does an operator/vendor need this, and if so, why? If you are the vendor for multiple CAMTS accredited programs isn't that an instant conflict? Need to reword this.

The committee agrees the completion of a conflict-of-interest statement does not preclude one from doing business, it just exposes explicit or implicit conflicts. We also received a comment to the same Standard in comment #21 and the committee agrees this should be moved from encouraged to required. The standard will be reworded to:

> **01.04.02** Conflict of Interest The BOD, administrative and management staff are ~~**encouraged**~~ **required** to complete an annual conflict of interest statement or form disclosing any actual or potential conflicts.

01.05.01 12 Page 1.7 TSA No fly Verification of patient/passenger identifications against TSA no fly list or applicable national regulations. Comment: I sent written documentation to remove requirements related to the TSA and the 12-5 program because it doesn't apply to medical transports. I think this standard slipped through. I understand a few operators are claiming their TSA reps say this is required for the passengers, but that doesn't make them correct. Our TSA rep says we can't use the No-Fly List for this purpose, so now I'm in a bind. This needs to be removed asap.

The committee suggested we reach out to the TSA for clear direction. We will attempt to gather more information. This remains open.

(Also being reviewed by the Aviation Advisory Committee)

01.05.01. 13.a page 1.7 FCPA "For FW International as applicable to the program's scope of services and service locations. a. Foreign Corrupt Practice Act (FCPA) 1. There is a policy that addresses how the program maintains compliance with the foreign corrupt practice act (FCPA) and monitors for transactions 2. Personnel are trained on the FCPA and ensure that all expenditures, transactions, ADDING a Standard and the Rationale.: dispositions, and payments involving program funds or assets are properly and accurately recorded in program's financial records 3. All payments made with program funds, or on behalf of the program, must be properly authorized. No undisclosed or unrecorded accounts are to be established for any purpose." Comment: If CAMTS accredits medical providers and therefore relies on the FAA for the aviations regulations, why is CAMTS involved in this? I don't think this is something that CAMTS needs to be involved in. Site Surveyors aren't going to understand it, nor do I think they need to.

The committee agrees not to make a change. CAMTS does not just address medical providers, but the entire program. The site surveyors for a specific program are selected based on their prior experience, so not all site surveyors need to be knowledgeable in every detail of every standard and not all standards are reviewed in every site survey. Some Standards are included to support improved patient care and/or safety and maybe be referenced if there are concerns.

(Also being reviewed by the Aviation Advisory Committee)

01.05.01. 13.b page 1.7 "b. General Data Protection Regulation (GDPR), UK Protection Act (FW International) 1. Determine if the transport will initiate, travel through, or terminate in an EU/UK country. 2. Limit the amount of information gathered prior to obtaining a signed Consent form. 3. Obtain a signed Consent form prior to disclosing patient information to any other parties. 4. When personal data has not been obtained directly from the data subject, document the identity and contact details of the person providing the data, why it was obtained indirectly, and for what purpose it is to be used (i.e. providing a quote for transport). 5. Retain the consent and any other documentation with the flight paperwork." Comment: Same as above

The committee agrees not to make a change. CAMTS does not just address medical providers, but the entire program and the standards apply to a number of programs who provide international services. The site surveyors for a specific program are selected based on their prior experience, so not all site surveyors need to be knowledgeable in every detail of every standard and not all standards are reviewed in every

site survey. Some Standards are included to support improved patient care and/or safety and be referenced if there are concerns.
(Also being reviewed by the Aviation Advisory Committee)

02.03.07 .2. g. Page2.14 "g. For international transports • An international checklist is available that includes information about specific locations, use of medical assistance companies, networking and local handlers. • Repatriation insurance, ICAO (International Civil Aviation Organization) regulations • Crew Safety – Policies address crew safety, including o Cultural intelligence o Assess travel risk to other countries and immunization recommendations using a reliable source (for example, the U.S. Department of State and CDC respectively and WHO)." Comment: I'm not necessarily opposed to this standard, but I think CAMTS should publish some sort of example or guide to give operators, and more importantly site surveyors, something to go by. JLI has an international checklist, but its aviation focused and doesn't cover some of this, nor should it. This would mean a second checklist, so who addresses it and is it kept? If so, how long?
The committee agrees that the use of an international checklist is imperative and should even include more preparedness information than those outlined here. For now, the committee agrees to make not changes, but allow the program to determine the details on the checklist based on the areas they service. We will, however, look for examples we can include in the next issue of "Best Practices".
(Also being reviewed by the Aviation Advisory Committee)

02.03.07 2. k Page 2.17 Individual survival gear carried on each crew member is strongly encouraged. At a minimum, the gear should include an appropriate signaling device. Comment: This should not apply to all FW. I think this is gross over thinking.
The committee agrees of make no change to the standard. As explained in the standard this is "strongly encouraged" and not required and the only item specified is a signaling device. The type of signaling device is specifically not defined and may include a signaling mirror, flare, orange ribbon, strobe, or even a pen light.

Date 01/25/2024 #15
Standard # - Suggested Change and Rationale for Change
06.04.03 Page 6.4 As an alternative to the flight hours in 06.04.03 1. and 2., a program may develop and submit a Pilot in Command (PIC) Experience Evaluation Tool. The tool should evaluate a pilot's education, training, and experience to determine if that pilot has the necessary background and experience to be a safe and effective PIC, taking into consideration the program's operation needs, scope of serve, service area, airframe type, operational environment, etc. To be considered as an alternative to meeting the Standard the program must submit a CAMTS Class Two Report of Change along with the Evaluation Tool. Once accepted, the effectiveness of the tool must be evaluated as part of the program's quality management process. The tool will be specific to the program, however an example that can be used as a starting point can be found in Addenda C. Comment: I think your evaluation checklist is a good start, but we need a process. The aviation subcommittee needs to step up and handle these evaluations and make a recommendation to the site surveyor(s), IMO.

The Aviation Advisory Committee does review each submitted evaluation tool and provides the program with suggestions. The site surveyors are not involved in these initial evaluations, however in subsequent visits they should be looking to see if the program made any of the recommended changes. This will be referred to the Aviation Advisory Committee for review.

06.05.01.4 Page 6.8 4. There is an annual review of infection exposure control, medical systems and installations on the aircraft, patient loading and unloading procedures for all mechanics. Comment: We really need to clear up to whom this applies. Every mechanic, or just employees of the operator? Outsourced repair stations?
For additional clarity, the committee agrees to the following wording change:

> **06.05.01.4** There is an annual review of infection exposure control, medical systems and installations on the aircraft, patient loading and unloading ~~**procedures**~~ **systems and equipment** for all **program** mechanics.

Date 01/25/2024 #16
Standard # - Suggested Change and Rationale for Change
03.05.01 1. d Page 3.16 Excerpts taken from a longer letter: CAMTS' Current Accreditation Standards Allow Animal Use Section 03.05.01(1)(d) of CAMTS' 12th edition "Accreditation Standards" states that "animal labs are also acceptable," in reference to the five successful airway management experiences required for providers. 2 There are numerous non-animal training methods—such as cadavers or human patient simulators (HPS), both of which CAMTS approves of in its standards—that are available for completing airway management training. Comments: Based on the information presented below, we request that the Commission on Accreditation of Medical Transport Systems (CAMTS) amend its Accreditation Standards to explicitly prohibit the use of animals in training, education, and certification in favor of human-relevant simulations at all member medical transport organizations—a policy that would align with CAMTS' core values of being "Fair, Ethical, Consistent, Accountable, and Patient and Safety Focused." Based on the aforementioned information, we urge CAMTS to add explicit policy language to its Accreditation Standards to prohibit the use of animals in training, education, and certification. Our suggested public policy language is, "CAMTS Accreditation Standards prohibit the use of animals for all associated trainings, education, and certifications, and instead require accredited programs to exclusively use human cadavers, human patient simulators, and other non-animal methods."
The committee strongly believes the standard should remain unchanged. While many programs have moved to primarily simulation, animal labs are still an excellent way to train when there is no regular/easy access to human cadaver labs. Discouraging animal labs would decrease quality training opportunities, which are in very short supply already. For the most part, animals used for training are classified as "food products" and when live animals are used, a veterinarian is often present or is involved in setting training and animal care parameters.

Date 02/08/2024 #17
Standard # - Suggested Change and Rationale for Change

01.06.02, 2., Page 1.10 Currently states "A policy requires staff to self-report any investigation, arrest or convictions" I suggest changing the wording to: "A policy requires staff to self-report any investigations, arrest, convictions, or licensure sanctions and/or other actions that may impact their ability to perform their role."

The committee agrees to the change. The standard will be changed to:

> **01.06.02, 2. A policy requires staff to self-report any investigations, arrests, convictions, licensure, or certification sanctions.**

03.06.01, 25, Page 3.37 Suggest changing the wording to: "Crews have life preservers easily accessible for operations over water. As an alternative, rotorcraft must remain within auto rotation of the shoreline." I think this should no longer just be "strongly encouraged" and should also apply to FW and surface (boats).

This is being referred to the Aviation Advisory Committee for comments.

Date 02/08/2024 #18

Standard # - Suggested Change and Rationale for Change

01.09.01 Page 1.14 Meeting minutes: The current standards basically require written meeting minutes; however, more and more hospitals and programs are moving to electronic capture of the meetings. There should be consideration to change the wording in this section to allow for electronic recording and of the meeting minutes. Many programs are also moving to using PowerPoints as their meeting documentation.

The committee agrees to not change the standards. Meeting minutes are designed to be a summary of the key discussions, actions, and follow-up. Written documentation needs to include those in attendance, by name and title, discussions, actions and follow-up and loop closure, without having to sit through a video or audio copy. PowerPoint presentations may meet this standard if attendance is included, notes are added with content of discussions, decisions, action items, assignments, and follow-up.

Date XX/XX/2024 #19

Standard # - Suggested Change and Rationale for Change

Left Blank **– No comment**

Date XX/XX/2024 #20

Standard # - Suggested Change and Rationale for Change

Left Blank **– No comment**

Date 04/05/2024 #21

Standard # - Suggested Change and Rationale for Change

Current standard states: “The Board of Directors, administrative and management staff are encouraged to complete an annual conflict-of interest statement or form, disclosing and actual or potential conflicts.”

01.04.02, Page 1.3 - change "encouraged" to "required". This is standard ethical business practice.

The committee agrees the completion of a conflict-of-interest statement does not preclude one from doing business, it just exposes explicit or implicit conflicts. We also received a comment to the same Standard in comment #14 and the committee agrees this should be moved from encouraged to required. The standard will be reworded to:

> **01.04.02 Page 1.4** Conflict of Interest The BOD, administrative and management staff are ~~**encouraged**~~ **required** to complete an annual conflict of interest statement or form disclosing any actual or potential conflicts.

01.02.01, Better under 02.03.07, 2.d, Page 2.13 - reflective material or piping on helmets for RW crew who engage routinely in overwater operations. This is routine for over-water RW aircrew in Coast Guard and US Navy. While benefit may be somewhat small (thankfully very few crashes and even fewer over-water), has been found in Navy investigations to decrease time to identify aircrew occupants seperated from their aircraft. No downside, with potential upside.

This suggestion was proposed during the last edition but was not included because of the concern of reflective materials covering cracks in the helmet shells during helmet inspections. We reached out to several Navy and Coast Guard pilots, and they encouraged the use of reflective strips. We received this response from CWO3 Jason Nix, ALSE/GSE MANAGER, USCG Office of Aeronautical Engineering (CG-41) "The CG for the most part has always used the reflective tape on our helmets. We apply 3 1'x16' strips on the helmets for the very same reason you mentioned. The tape for the most part is easy enough to remove if the user has suspicion that there may be a crack. We typically conduct a thorough inspection yearly, but the user does a visual inspection before each flight.

For the most part, cracks are rare on our helmets unless the user banged their head or dropped the helmet. In those cases, I would remove the tape and re-apply after inspection and using rubbing alcohol to clean tape residue.

As far as manuals, we use our internal guidance on helmet inspections, but it is basically a thorough visual inspection of the entire helmet. If we find any discrepancies that can't be fixed by a part replacement, then we just issue a new helmet. We do work in a saltwater environment, so most issues occur with comms parts and degraded inserts."

Another Coast Guard pilot stated that inspections for cracks can also be done by removing the web and padding and inspecting form the inside of the helmet. He also pointed that adding the reflective materials is not much different for added Velcro for the NVGs

The committee agreed to include the wording that was removed at the last minute from the 12th editions. The size, shape, and extent of the reflective materials is left to the program. The standard will state:

02.03.09 2. d Head Strike Envelope

- **Helmets have reflective striping or other markings that can be seen in the event the wearer is in the water or other environments requiring search and rescue**

(Also being reviewed by the Aviation Advisory Committee)

03.07.01 #7. Page 3.38: Remove requirement for annual TB testing. No longer required anywhere in the United States.

The committee agrees with the existing standard, however, believes there could be more clarification. The wording will be changed to:

03.07.01 # 7. Programs conducting international transports or operating in localized regions determined at high risk for tuberculosis, must provide annual tuberculosis testing (purified protein derivative), as consistent with current and other testing, screening, and vaccinations, and as consistent with current national guidelines (such as the WHO, CDC, AHJ). This includes medical personnel, pilots, and mechanics.

01.05.01 #7, Page 1.6 - transport organization is not beholden to EMTALA, it is the sending ER that is responsible. There is no requirement and there is no power inherent to the transport organization to alter and consider this. It is a source of wide-spread confusion in transport organizations, primarily, again since there is no specific mandate for the transport organization itself. Would remove
The committee agrees to leave the standard unchanged. While EMTALA may not apply to some programs, it might apply to others. Regardless, the committee believes all program personnel should understand EMTALA concepts and requirements.

Same with **03.02.12., Page 3.10** This is not a reasonable ask of a transport organization to police the sending hospital compliance. Would remove.
The committee agrees to leave the standard unchanged. While EMTALA may not apply to some programs, it might apply to others. Regardless, the committee believes all program personnel should understand EMTALA concepts and requirements.

Date 04/16/2024 #22
Standard # - Suggested Change and Rationale for Change
03.01.03 (2)(a), Page 3.4 - Can we please clarify primary provider experiential requirements? Either pick a timeframe (i.e., 3 years) or an hourly requirement (i.e., 4000 hours), but not both, since they do not agree with each other. Standard full-time employment is between 1872 (0.9 FTE) to 2080 (1.0 FTE) hours per year, meaning 4000 hours is around 2 years of FT experience (+/- based on FTE status). If 4000 hours is all that is required, we could bring candidates with FT experience in an entire year earlier at 2 years; if we need to wait 3 years, I suggest increasing the hourly requirement to between 5,000 to 6,000 hours to account for 3 years of actual FT practice. Alternatively, remove the "years" requirement altogether and just set an hourly requirement, since that is a more objective way to measure someone's experience regardless of their FTE during that timeframe.
The committee agrees the wording can be confusing and will change as below.

03.01.03 2. a. The primary care provider of the clinical care crew may be a resident or staff physician, advanced practice nurse, registered nurse, physician assistant, or a paramedic. The primary care provider must have 3 **full time equivalent** years of critical care experience. (Critical care experience is defined as ~~**not less than 4000 hours**~~ experience in an ICU or an emergency department.) In addition, clinicians in the primary-care-provider role must have pre-hire experience and/or education in the medications and interventions as defined in the program's scope of care and services.

Date 04/24/2024 #23

Standard # - Suggested Change and Rationale for Change

01.08.01 4. b, Page 1.13 - Reflective vest.

The current wording implies that safety vests are optional during the day and only required at night. OSHA Standard 1926.651(d) states: "Employees exposed to public vehicular traffic shall be provided with, and shall wear, warning vests or other suitable garments marked with or made of reflectorized or high-visibility material." I suggest leaving the existing wording in the Standards but delete the word "night"

The committee agrees and will delete the word "night". The new wording will read:

> 01.08.01 4. b. High-visibility reflective vests or appropriate Department of Transportation (DOT) approved clothing worn by flight and ambulance crews in accordance with ANSI-SEA 107 standard or equivalent national standard (required for medical crews and vehicle operators responding to **~~night~~** scene requests).

Date 04/27/2024 #24

Standard # - Suggested Change and Rationale for Change

Move the entire standard **04.08.04** regarding PAIP to the 02.03.00 safety management section, suggest to new standard numbered 02.03.08. Too often the medical transport systems consider PAIP a responsibility of the communications center and then, too often PAIPs are not completed, in some cases because of poor support from management. Moving this standard under safety is appropriate since PAIP drills represent a safety item and also elevates it to the safety department responsibility, where I believe it will be completed more consistently since we all say, "safety first".

The committee agrees the Post Accident/Incident Plan section is more than a communication center responsibility and this entire standard 04.08.04 is better positions within the safety standards. The committee also agreed to add the wording "or Emergency Response Plan". This will be moved and become 02.03.08.

Move standard **04.08.06** regarding participation in regional disaster preparedness drills to the first sentence of 1. under 03.05.03 Community Outreach Safety Program as the participation in regional drills is not a function of the communication center, but a function of the entire medical transport system as a whole, and this section already speaks to involvement in regional disasters.

The committee agrees this standard is better position under the Community Outreach Safety Program and will be moved to 03.05.03.

Three-part suggestion. Time to move **03.02.02 10**. Just Culture for physician medical directors to to required rather than strongly encouraged. Add in, "(at least every three years)" to this requirement as once every three years is both reasonable and consistent with other medical director requirements. Consider adding the language, "or equivalent" because just culture is a component of High Reliability

Organization (HRO) training, which is a hospital requirement of many physicians (unless you think it is unique enough, then leave this last suggestion out).

The committee agrees with this change and will make the following wording changes:

> 03.03.02 10. "Just Culture" and "Informed Culture" or equivalent education ~~**is strongly encouraged**~~ **(at least every three years)** (see References).

Time to move **03.02.08** safety and risk management training for physician medical directors to required.

The committee agrees with this change and will make the following wording changes:

> 03.02.08 The medical director(s) receives safety and risk management training on an annual basis ~~**(strongly encouraged)**~~.

Three-part suggestion. Move **03.02.09** regarding medical directors orienting physicians that provide on-line medical control to the 03.02.14 Medical Control section as the last sentence of 1. because as a stand-alone, 03.02.09 is duplicative and has different language. Specify this orientation requirement for on-line physicians, "at least every 3 years" because there may not be yearly changes to discuss but likely within three years, something important will have changed that on-line medical direction needs. Change the name of this whole section from, "Medical Control" to, "On-Line Medical Direction" which is the language that NAEMSP uses and then change, "medical control" to, "medical consult" throughout this section.

The committee agrees with this change but also believes that orientations or updates should be more frequent if changes are made to the programs protocols or policies that impact patient care.

Standard 03.02.09 will be moved and become part of Standard 03.02.14 and that section will be retitled and part renumbered. We will make the following wording changes:

> 03.02.14 ~~**Medical Control**~~ **On-Line Medical** Direction
>
> 1. The medical director(s) is actively involved in orienting physicians providing on-line (in-transport) medical direction according to the policies, procedures, and patient care protocols of the medical transport services. **Periodic updates will be provided whenever there are changes to the protocols or program policies that may impact patient care.**
>
> **2**. ~~**Medical Control**~~ **On-Line Medical Direction** Physicians- On-line medical ~~**control**~~ **direction** physicians who are trained and identified by the service must be available 24/7/365 and have the appropriate knowledge base and experience sufficient to ensure proper medical care and medical control during transport for all patient types served by the medical transport service.
>
> **3.** If the medical ~~**control**~~ **direction** physician's experience is lacking in a clinical area, he or she must seek prompt consultation as appropriate to ensure proper medical care and medical control during transport for all patient types served by the medical transport service. This consultant should be an appropriate designated physician or the patient's receiving attending physician.

4. Medical ~~**control**~~ **direction** physicians are provided with triage guidelines to determine appropriate transport mode and team composition, and on-scene triage guidelines developed and accepted by the specific EMS region. See References. (RW)

a. Triage guidelines may include provisions for auto launch if part of the scope of service

Time to move **03.03.06 4**. just culture for the clinical care supervisor and **03.04.01** 2. just culture for the program manager to required. Time to move 03.03.06 15. safety and risk management training for the clinical care supervisor and 03.04.01 5. safety and risk management training for the program manager to required.

The committee agrees and will change the wording:

03.03.06

4. "Just Culture" or equivalent education ~~**(strongly encouraged)**~~

03.04.01

2. "Just Culture" or equivalent education ~~**(strongly encouraged)**~~
5. Safety and risk management training on an annual basis ~~**(strongly encouraged)**~~

Time to move **03.06.01 5.** a. regarding seated position in ambulance while managing airways from strongly encouraged to required as we don't want our medical providers unbuckling in a moving vehicle.

The committee agrees and will change the wording:

03.06.01 5.

a. ~~**In an ambulance it is strongly encouraged that seating be designed in the ambulance**~~ **Ambulance seating shall be designed** so that patient care can be rendered from a seat-belted position. Use of shoulder harnesses on side facing bench seats are discouraged based on peer reviewed studies regarding front end collisions. (See References) (S)

Edit: remove the bold from the number 9. under 03.03.06

Thank you for catching this typo.

Date 05/21/2024 #25

Standard # - Suggested Change and Rationale for Change

03.05.01 2. b, Page 3.18 (and others). The current standard states" "Clinical and laboratory continuing education must be developed and documented on an annual basis as pertinent to scope of care to follow." Many programs have moved away from annual clinical rotations and/or HPS and are using actual patient transports to account for clinical rotations. While the program may have written objectives there is no third party to acknowledge the objectives were met or that the patient care was appropriate. (Must be OK it the patient did not deteriorate?) I suggest the committee address and clarify what is acceptable evaluation on annual clinical rotations.

This suggestion is being referred to the CAMTS Education Committee. The Standards Committee believes with clearly defined clinical objectives, documentation completing the objectives for each clinical area on an annual basis, and close quality review may meet this standard.

03.05.01 3. Page 3.18 Competencies - Second sentence currently reads "Where available for the role and patient population(s) transported. a transport-specific certification is strongly encouraged." Suggest changing this to "required".

The committee agrees and the wording will be changed to:

> Where available for the role and patient population(s) transported. a transport-specific certification is ~~strongly encouraged~~ **required.**

Date 05/21/2024 #26

Standard # - Suggested Change and Rationale for Change

06.04.03, Item 5: "Ground" used in this context is not standard phraseology and not familiar.

This was an editing error. The word should have been "green".

06.04.03, Item 5: This standard specifies that two pilots working together must have 250 hours in M/M between the two of them. However, single pilot operations have no such requirement. An operator, in this scenario, could elect to exceed the standard by using two pilots in an aircraft certificated for single pilot operations but would have more restrictions than if they were operating the aircraft single pilot. Furthermore, it is very difficult for an SIC to log time in an aircraft certificated for single pilot operations. Recommend changing this standard to only apply to aircraft REQUIRING two pilot operations (predominantly part 25)

The committee agreed to make no changes to the standard.

(Also being reviewed by the Aviation Advisory Committee)

Date 06/06/2024 #27

Standard # - Suggested Change and Rationale for Change

3.05.01 3. f, g, and h - Make consistent and similar language across RN/Paramedic/RT. C-NPT is required for RNs but recommended for Paramedics and RTs. It should be encouraged for all disciplines, but not required.

The committee agreed to make no change to the standard.

………..

In the following submission (#28), the text in black is the recommendation and will be posted on the website along with the committee response. The text in green was the rationale submitted. For brevity we will not publish the comments in green.

Date 06/11/2024 #28

Standard # - Suggested Change and Rationale for Change

New Standard: Program administration will demonstrate execution of their duties and responsibilities including addressing major issues within a reasonable time period, following basic problem solving

principles, executing sound business decisions, demonstrating financial responsibility, heeding facts, data and expertise, and demonstrating competency, integrity, professionalism, and leadership that supports the quality and safety standards of CAMTS. Program administration will provide adequate resources to effectively operate the program including promoting recruitment and retention, Rationale: During our last site survey, there was not an applicable CAMTS standard available to address an administration that had gone off the rails, other than the standard regarding strategic planning. Administration redefined the term "dereliction of duty", responding only to crisis situations and not always then. They repeatedly failed to provide the needed resources to operate the program or address the multiple, major issues it faced. The results of the neglect along with extraordinarily delayed, poor or absent decision-making was and continues to be devastating to the quality and safety of the staff and patients. Delays in decision-making or not making decisions also cost the program/hospital more money unnecessarily, funds that could have been used to provide the needed resources. When the Chief Nursing Officer reviewed the letter from the CAMTS Board saying that her plan did not comply with the safety standard, the standard was intended to protect the lives of crews and patients and that other programs that had adopted similar plans had failed accreditation, her response was "Do we have to be accredited?" She also had the head of human resources attend this meeting as she went over how I was going to help implement her plan that violated the CAMTS standard. Administration should support CAMTS standards, not eliminate the program director trying to uphold CAMTS standards. Should the discussion on this or other suggestions go to CAMTS doesn't need to write standards for one program, I sincerely hope we are a one off. However, I can say as a former site surveyor, all surveys pre-pandemic, I saw a couple that were alarming. Regardless, when something reprehensible happens, most of us want to do all we can to prevent a recurrence. And although this is only one program, 80 employees and 2500+ patients a year are impacted.

The committee believes that these are primarily human resources issues and are covered under other existing standards. Issues within surveyed program are likely to highlighted in the comments and scores of the Safety Culture Survey and can then be tied back to an existing Standard. The committee believes no changes to the existing standards are needed.

New Standard: Vehicles will be in service at least 80% of the time. Rationale: At the program where I worked, in a period of 10 months, there were 3 occasions when all 3 ground ambulances were out of service, on the third occasion for 7 weeks. One of the ambulances was out of service from August 2022 until January 2024, 1 year, 5 months. This was due to the extreme age of the vehicles, very high mileages exceeding 350,000 to 600,000 coupled with the ground vendor's inability to staff more than one mechanic for their 65 ambulances plus ours. Accordingly, the back up ambulances became the primary ambulances. This resulted in the transport team, for the majority of the time, transporting the sickest patients in the state/region in regular ALS/BLS ambulances. Similar story on the air side with the fixed wing aircraft being out of service multiple times for months at a time, up to 5 consecutive months on one occasion, due to the age of the aircraft along with limited availability of parts due to the small number of this aircraft manufactured and utter failure of administration to address this anticipated and well communicated scenario. This was compounded by the fact that the backup aircraft was available only 12 hours/day which served very poorly for a busy program transporting the sickest patients in the region, including children and neonates. The first day of our site survey, all of our vehicles were out of

service. In service time would be a good objective measure of a program administration's ability/inability to strategically plan and provide functional vehicles equipped to support critically-ill patients. A year after having received the CAMTS decision letter and being cited for lack of strategic planning on vehicles, there is still no timeline to replace any of the aged vehicles nor even a plan as to when they will have a plan. (Should this suggestion be approved, it may be considered to solicit the days in service in the PIF).
In-service times cannot be guaranteed and may be impacted by many issues outside the control of the program. This is covered under Standard 01.02.02 on Financial Commitment and should also be included as part of the program's quality management process, especially if vehicle or equipment availability or maintenance is an issue. These are likely to be shown in the Safety Culture Survey results. The committee agrees to no changes in the Standards.

New Standard: There will be written policies addressing hiring and supervision of the communication specialists if these individuals are not employed by the program. If not employed by the program, there will be a direct reporting line of the communications specialist supervisor to the program's senior management. All communications specialist supervisors will have knowledge and experience commensurate to the mission, for example, at minimum a paramedic for critical care and at least two years of experience in medical transport. Rationale: There are currently no minimum requirements for this role that oversees the communications specialists - the employees running the program minute to minute and on the frontlines of safety. Nor is the supervisor required to have any of the training that the communication specialists have. It does not make sense that, in effect, someone off the street could be in this role nor did I see this in practice at the programs I surveyed that did critical care. At the program where I worked, the individual given hiring authority and to whom the communication specialists report to has no clinical background and no knowledge/experience in medical transport except occasionally setting up regular ambulances for inbound/outbound ALS/BLS hospital patients. Her first hire decision was made without the approval of the transport program nor communicated to the transport program after she hired the individual. (The transport program found out incidentally when a friend of the hiree told one of our communication specialists that her friend was going to be working there – a surprise to all.) Performance evaluations will also be the responsibility of this person given hiring authority with her having virtually no ability to make these assessments. As the new hiring manager has no reporting line to the transport program, the transport program has officially no control over this critical aspect of the operation. PIF attachment #95 already touches on this: "Procedure, contract or letter agreement that describes how the Part 135 certificate holder interfaces with the communications center (creating and revising policies, hiring and supervising personnel, etc.) if communication specialists are not employed by the certificate holder." but this verbiage/concept is not reflected in the standards. We have an existing similar CAMTS standard: 03.03.01 If transport nurses are part of the medical team, they must report to a nurse or physician on clinical issues This suggests that it is desirable to have someone with the appropriate knowledge base to address issues and to evaluate performance. JCAHO requires nurses report to a nurse. The same concept would be desirable for communication specialists.
The committee agrees this appears to be a program specific issue. There are many configurations of communication centers and staffing. With appropriate training of the communication specialists,

programs have shown staffing coverage can be done without requiring clinical certification. The committee agrees to make no changes to the Standards.

04.03.01. 2.b. There are relief personnel with the appropriate training available for periodic breaks. Suggest amending to: There are relief personnel with equivalent training immediately available for periodic breaks, employee emergencies/mid shift vacancies and/or surges in activity from fellow communications specialists, the communication specialist supervisor, or another Suggestion for ADDING a Standard and the Rationale.: manager. Rationale: Because administration eliminated the director position and left an RT who did not meet the job requirements for a communications specialist at our program, the staff communication specialists were left with no relief if they become ill, have an emergency during their shift, or are experiencing peak volume periods needing assistance. The program is allowed only 1 communication specialist on duty 24/7. This role is critical to safety. Of relevancy, in the 3-26-2016 helicopter crash in our state killing all 4 on board, one of the contributing factors cited by the NTSB was "the operator's inadequate oversight of the flight by its operational control center" during adverse weather conditions.
The committee believes this is already covered in the communication center and financial commitment standards. The committee agrees to no further changes to the Standards.

The number of management positions must be appropriate to the mission, scope, vehicle configuration, volume and complexity of the program. Rationale: There is currently no standard for a minimum number of management. At the program where I worked, over a two year period, administration reduced the number of management positions from 3 to 2 then to 1 while all during this time the program continued to experience substantial volume increases. The workload was overwhelming at 2 managers as confirmed by the lead CAMTS site surveyor who said at the closing that in her 22 years as a site surveyor and working with 35 programs within her own organization, she had never seen so much workload placed upon two managers. Four months after this statement, administration reduced it to one manager. Thus far, at 11 months, the remaining manager is still trying to run the program alone, many tasks are not getting done, including quality management, no quality or safety committee meetings have occurred for 1 year and counting, some staff don't report issues because they know the manager is completely overwhelmed, expired controlled substances have not undergone reverse distribution for over a year resulting in a very large inventory of expired narcotics, etc. While there were two managers, a long list of work not getting done was submitted to administration with one of many formal requests for a third manager. No action was taken by administration.
The committee believes that these are primarily human resources issues and are covered under other existing standards. Issues within surveyed program are likely to highlighted in the comments and scores of the Safety Culture Survey and can then be tied back to an existing Standard. The committee believes no changes to the existing standards are needed.

01.06.04 Replace "are encouraged to" with "will" in the standard: "Programs are encouraged to develop a plan for succession and unanticipated extended absence for key positions. The plan should address position vacancies, including when there is no incumbent to provide transition training, as well as unplanned extended temporary absences, designed to preserve the integrity of the program." Rationale:

I was inspired to write this standard after having witnessed the deleterious effects upon programs during site surveys from the departure of key individuals who took their knowledge with them. This along with myself advancing in age and having invested most of my adult life in the program, I wanted to ensure knowledge and experience was not lost. I was practicing this standard until we were reduced to two managers when we were forced to put it on the back burner. With only 3 hours notice that I was having my last day at work, there was zero transition and much of 40 years of knowledge is lost. With the exception of a monthly financial report, the work I did has not been getting done and there is no one there to train a new manager to do the work. Succession planning is a key priority of major corporations. Case in point, spring 2024, at center of the struggle over the Disney board's membership, the board was cited for failure to properly oversee the succession process. Disney's business is entertainment. Ours is patients' lives.

The committee believes that these are primarily human resources issues and are covered under other existing standards. Issues within the program are likely to highlighted in the comments and scores of the Safety Culture Survey. The committee believes, for the 13th Edition "encourage" is still appropriate and no changes to the existing standards are needed.

01.02.01 Add "including market pay practices" as follows: There must be evidence of financial commitment to the program by the administrative structure including market pay practices and through financial resources that provide excellence in patient care and safety of the transport environment

Rationale: I am aware that CAMTS has not broached the compensation realm. However, this is another way hospital administration severely crippled our program. Hospital administration downgraded the original manager position they opened to an assistant manager position making the pay only ~$5 more per hour than a staff position for a highly stressful, quite undesirable job in a resource starved program. It remains unfilled. There were three other chapters where compensation decisions substantially impaired the program: gross underpayment of the communication specialists along with a protracted timeline to resolve it; this resulted in an 18 month period with in ability to hire due to the unknown pay rate and some communication specialists regularly being on duty 60 hours/week for years. Another chapter was when administration cut the pay of the prn neonatal nurse practicioners by 15% resulting in our losing half of our prn team which was 80% of our NNPs. They were highly experienced (a combined 81 years of neonatal) and largely irreplaceable, recruitment further impeded by our having the lowest NNP prn rate in the region. It would be another 4 years before another NNP was hired (after they finally increased the prn pay) and the program experienced years of chronic vacant shifts/patient delays for the busiest neonatal team in the state. The QM data of these delays along with anecdotes of the negative impact on neonates' conditions, including deaths, were reported and repeatedly failed to elicit a response. Lastly, as they reduced the management from three to two, the taking on of additional responsibilities by the two was never followed by an increase in pay. Likewise, when the Director position was eliminated, this left one remaining manager who was filling the roles of three managers, bearing ever increasing transport volume and combatting extraordinary time-consuming, hospital administration inefficiency in trying to carry out the job. Other than annual merit increases of 0 to 3% for all hospital employees, this manager has continued to receive the same rate of pay which is less than some of the clinical team members he oversees, 11 months and counting.

The standards committee believes this is outside the scope of CAMTS and is primarily an internal human resource issues. No changes to the standards.

03.06.01 8.g. There is a policy to monitor individual nurse/practitioner use of controlled substances to detect/alert management of possible controlled substance diversion. Rationale: Unfortunately no program or any healthcare setting that stocks controlled substances is immune to controlled substance diversion; it happened twice at our program. In one of the cases, there was known repeated administration of normal saline instead of pain medication to a patient in severe pain on a long international transport. Risk of diversion can be higher on transport versus other healthcare settings where controlled substances are taken off site every transport and, depending on the practice of the program on how/where controlled substances are stored during transport, there is potential of little to no observation at times. This issue came to light recently as there is insufficient management now to carry out this important oversight.
The committee agrees with this recommendation and believes it is best placed under both initial and annual training for both clinical and management staff. The following changes will be made:

03.03.06 The clinical care supervisor must demonstrate currency in the following or equivalent educational experiences as appropriate to the mission statement and scope of care and/or the clinical care supervisor must have immediate access to personnel with appropriate knowledge and experience as consultants. Education on didactic topics is on an annual basis.

10. Identification and response to actual or suspected medication diversion. *(also results in new numbering)*

03.04.01 The program manager must demonstrate currency in the following or equivalent educational experiences as appropriate to the mission statement and scope of care. Didactic education initially and on an annual basis must include but not be limited to:

5. Identification and response to actual or suspected medication diversion. *(also results in new numbering)*

03.05.01

2. Continuing education/staff development must be provided and documented for all full-time and part-time Critical Care and ALS Providers. These must be specific and appropriate for the mission statement and scope of care of the medical transport service.

a. Didactic continuing education must include an annual review of:

- Human factors – Crew Resource Management - AMRM (Air Medical Resource Management) (See References)
- Exposure control
- “Just Culture” or equivalent education – strongly encouraged.

- Safety and risk management training on an annual basis (strongly encouraged)

- Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

- **Identification and response to actual or suspected medication diversion.**

- State EMS rules and regulations regarding surface and air transport

- Stress recognition and management/resilience

…….

Date 06/21/2024 #29

Standard # - Suggested Change and Rationale for Change

03.05.01 (3)(f) page 3.16 - For Specialty Team i.e. Neonatal and High-Risk OB (Our Program has a Perinatal Specialty Team that does High-Risk OB & Neonatal Transports (Team combo OB Flight RN, Neonatal NICU Flight RN, & NICU Flight RT). With the current standard by Jan. 2025 our Specialty RNs would need to have a flight-specific advanced level cert., such as CNPT (or plan in place to have all RNs to get the C-NPT). Currently, all our Specialty RN's have their RNC-OB/RNC-EFM or RNC-NIC. With the current standard, they would be required to get C-NPT ... We feel that the RNC-NIC and RNC-OB/RNC-EFM are more valuable to our RN's than the C-NPT would be... First, the RNC's relates to their specialty patient population for the specialty team, and second, the C-NPT has far fewer eligibility requirements to be able to take the exam than do the specialty RNC's exam's eligibility requirements. Thanks for taking the time to address this!

The committee agreed to make no changes to this standard. The specialty certifications above are great for in-hospital patient care, but do not address patient transport specific content that is an expansion to the hospital role.

………..

Date 06/24/2024 #30

Standard # - Suggested Change and Rationale for Change

01.07.01 to correct an inconsistency - Standard discusses scheduling, individual work shifts, strategies to minimize fatigue, # of shifts/wk and day to night rotations. 1. under this general standard addresses shifts scheduled for more than 12 hours but d. in this section addresses the right to call "Time Out" regardless of shift length. I suggest we move 1.d. to number 1 and relabel criteria for shifts scheduled more than 12 hours as 2 (leaving a, b, c, e and f) and renumber the following entries as necessary.

The committee agrees and will change the wording and numbering.

> **01.07.01** Scheduling and individual work schedules demonstrate strategies to minimize duty-time fatigue, length of shift, number of shifts per week and day-to-night rotation. (See References for circadian rhythm, Fatigue Risk Management System (FRMS) and other fatigue studies.)

1. ~~d. Medical~~ Personnel must have the right to call "time out" and be granted a reasonable rest period if the team member (or fellow team member) determines that he or she is unfit or unsafe to continue duty, no matter what the shift length. There must be no adverse personnel action or undue pressure to continue in this circumstance.

a. Management must monitor transport volumes and personnel's use of a "time out" policy.

b. A fatigue-risk management system is utilized.

~~1~~2. The following criteria must be met for shifts scheduled more than 12 hours.

a. Medical personnel are not required to routinely perform any duties beyond those associated with the transport service.

b. Medical personnel are provided with access to and permission for uninterrupted rest after daily medical personnel duties are met.

c. The physical base of operations includes an appropriate place for uninterrupted rest.

(This will also change the numbering of the remaining section.)

…….

Date 07/25/24/2024 #31

Standard # - Suggested Change and Rationale for Change

Definition of Neonatal Transport: Should take into account corrected gestational age. Recommend consideration of corrected gestational age (<= 44weeks) or <28 days of life if term or post term.
28 days of life on a VLBW or ELBW infant is too soon to opt for transport without neonatal experience and equipment.

This was refered to our AAP and NAAN representatives for comment.

From Robert Holcomb, MD, AAP: *"Agree 100%. In Itasca, Dick and I talked a little about this. All too often these EMS services claim to do neonatal transports and yet don't even have a transport isolette. As we move towards ensuring the true critical care neonatal transports are accomplished by specialty teams, this is a great step in that direction*".

From Tammy Rush, NAAN: "*So very important in tracking development especially when born premature. Please consider adding Corrected Gestational Age.*"

From Linda Meiner: " *I have always supported this but we had trouble obtaining corrected gestational age on the neonates and little things that showed up in ED's so we started using the following to define a neonatal transport:*

The infant is 30 days or less OR if the infant weighs 5kg (or 10lbs) or less OR if the infant is still being cared for in a NICU.

This simplified the question for our callers, most can answer chronological age and weight on the initial requesting call - used this for over 40 years and there is a little grey zone in the upper margins but it works well to match team and patient needs."

We also reached out to the person that submitted the suggestion to ask if they were speaking more toward the team or the use of an isolette. His response: *"Actually both. While the isolette is required for temperature stabilization, that is only a small part of the more complex issues presented by premature infants. This is also complicated by the needs of infants with severe BPD, who require ventilator settings far from the norm.*

I think that the use of specialty teams for special patients needs to be a national standard, rather than a preference."

The committee believes that the program needs to establish a policy on their criteria for using an isolette and/or specialty team(s). We will add the following wording to 01.04.06:

> **01.04.06** All patient care resources, including personnel and equipment, necessary to the program's mission must be readily available in the transport vehicle or available to place in the transport vehicle, and they must be operational prior to initiating the mission. This includes resources, personnel, and equipment provided by Specialty Care Providers.
>
> 1. **If within the program's scope of services, the program will have a policy that defines neonatal patients and when an isolette and/or specialty team will be used on transports.**

……….

Date 07/31/24/2024 #32
Standard # - Suggested Change and Rationale for Change
03.01.02 - 3. and 03.01.03 - 3 - Medical Director: Add "Strongly Encourage" EMS Board Certification for Medical Director requirements.
With increased availability of specialty training in EMS for physicians, this background is increasingly becoming the standard. I would not make it a requirement, but it certainly is something newer medical directors should strive for or have in their background.
The committee agrees and the wording will be changed to:

> 03.01.02 3. The medical director should be board-certified in emergency medicine**. Board certification in Emergency Medical Services is strongly encouraged.** ~~, but~~ **If** he or she is not, it is strongly recommended that the medical director be board-certified in **critical care**, family medicine, internal medicine, surgery, or pediatrics with demonstrated EMS education or 5 years of experience in emergency medicine.

03.01.02 - 4. Equipment: Add "Strongly Encourage" Video laryngoscope" . The evidence strongly points to VL as the preferred approach when using standard metrics of success (first pass success, lack of

hypoxia, time to intubation, etc...). This is especially true in "low frequency intubators" which includes all EMS by definition. I think it will take time for the industry to transition as a whole, so strongly encouraged seems appropriate with this version.

The committee agrees and will make the following change related to ALS equipment:

03.01.02. 4. Equipment – includes all equipment in BLS, plus:

a. Video laryngoscope (strongly encouraged)

b. Ventilation: Ventilators and non-invasive ventilators (CPAP/ Bilevel Positive airway Pressure) with the capability to utilize blended gases

c. Cardiac monitoring, pacemaker, and defibrillator

d. Non-invasive monitoring (e.g., waveform capnography, pulse-oximetry)

03.01.03 - 4. Equipment: Add "Video Laryngoscope and blades appropriate for the scope of patient care" as required. See above rationale. CCT teams are typically better resourced and more nimble and should be able to make this transition (and probably should have already)

The committee agrees and will make the following change related to ALS equipment:

03.01.03. 4. Equipment – includes all equipment in BLS and ALS, plus:

a. Video laryngoscope and blades appropriate for the scope of patient care

~~a~~b. Ventilation: Multimodality ventilators capable of invasive ventilation (pressure, volume, ventilator appropriate to all age groups transported)

~~b~~c. Invasive hemodynamic monitoring, central venous pressure, and arterial pressure

03.01.04 Specialty Care: 4/a: Remove Transcutaneous Ventricular Assist Device. No service carries their own VADs. Managment? Yes, but carrying the equipment is not useful or realistic.

The committee agrees and will delete this item:

03.01.04 4. Equipment - Includes all equipment in BLS, ALS, and Critical Care plus: (as appropriate to the scope of care)

~~a. Transcutaneous ventricular assist devices (e.g. LVAD, BiVAD, RVAD)~~

a~~b~~. Inhaled gases (e.g., nitric oxide, helium oxygen, aerosolized prostacyclin)

b~~c~~. Neonatal isolette with heart rate monitoring device and size appropriate ventilator (with blender for adjustable oxygen delivery), thermoregulation control and infusion devices (syringe pumps).

c~~d~~. Fetal doppler/fetal heart rate monitoring device (if transporting High Risk Obstetrics – HROB). For long range transports, external cardiotocography monitoring device is required.

03.02.00 - Medical Direction: Same comment about EMS Board Certification

O3.02.00 is about the responsibilities of the medical director and does not address specific board certification requirements.

02.03.05 (2) - would add clinical leadership to the make-up of the committee. Risk mitigation strategies and risk tolerance should include consideration of impact to the patient - the one party without a voice in the decisions. Without weighing clinical impact of decisions, the answer would always be to mitigate risk by not leaving base.
The committee agrees to make no changes. Some programs specifically do not include leadership in safety meeting to encourage more staff interaction and input.

05.05.02 and 06.05.02 - change this to "Must have a policy for ..." rather than just a demonstrated practice. This would be consistent with the rest of the standards where we look for both written policy and demonstration of compliance rather than just demonstration of compliance.
The committee agrees and will change the wording in both the RW and FW sections to read:

> 05.05.02 and 06.05.02 Staffing – **Written operation policy addresses** a single mechanic on duty or on call 24 hours a day must be relieved from duty for a period of at least 24 hours during any seven consecutive days, or the equivalent thereof, within any one calendar month. In addition:
> …..

……..

As of September 1, 2024
Any new comments received after this date will be continued on a new log.

67 comments/suggestions received from 32 people